99-4643-510
DDG
MARK MEOLA

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25501

Certificate of Death

Reg. No.

AMEND ITEMS: #23 PART I, 27, 28A-F PER MEO G770 8-23-99 WR

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARK S. MEOLA
2. Date of Death (Month, Day, Year): AUGUST 10, 1999
3. Time of Death: 1238 PM
4a. Facility Name (If not institution, give street and number): BAYVIEW MEDICAL CENTER
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-92-4761
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 34 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 28 1965
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.
10b. County: Anne Arundel Co.
10c. City, Town or Location: Pasadena
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 803 222nd. Street
10f. Zip Code: 21122
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): self-employed
16b. Kind of Business/Industry: Electrician

17. Father's Name (First, Middle, Last): Salvatore Meola
18. Mother's Name (First, Middle, Maiden Surname): Rosemarie Creamer

19a. Informant's Name/Relationship (Type, Print): Michael Meola (Brother)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 803 222nd Street, Pasadena, Md. 21122

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Dulaney Valley Mem. Park
Date: 8/13/99
20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: George M. Hampton Jr.
22. Name and Address of Facility: McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Md. 21122

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. COMBINED NARCOTIC INTOXICATION WITH COMPLICATIONS
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [X] Could not be determined

28a. Date of Injury (Month, Day Year): Found: 8-9-99
28b. Time of Injury: FOUND: 8:14 P M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: UNKNOWN
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): RESIDENCE
28f. Location (Street and Number or Rural Route Number, City or Town, State): 7244 STRATTON WAY, BALTIMORE, MD.

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Theodore M. King
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): AUGUST 11, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THEODORE M. King 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): AUG 13 1999
32. Registrar's Signature: Geneva G. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

DDG
MARK MEOLA

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #23 PART I, 27, 28A-F PER MEO G770 8-23-99 WB

Certificate of Death

Reg. No. 99 25501

Physician / Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
MARK S. MEOLA	AUGUST 10, 1999	1238 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
BAYVIEW MEDICAL CENTER	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-92-4761	1 [X] M 2 [ ] F	34 Yrs.			June 28 1965	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Anne Arundel Co.	Pasadena	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
803 222nd. Street	21122	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
9	0	self-employed	Electrician

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Salvatore Meola	Rosemarie Creamer

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Michael Meola (Brother)	803 222nd Street, Pasadena, Md. 21122

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Dulaney Valley Mem. Park	8/13/99	Baltimore, Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
George M. Hampton Jr.	McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Md. 21122

Physician / Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. COMBINED NARCOTIC INTOXICATION WITH COMPLICATIONS	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [X] Yes 2 [ ] No	1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
[X] Yes 2 [ ] No	Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [X] Could not be determined	Found: 8-9-99	FOUND: 8:14 P M	1 [ ] Yes 2 [X] No	UNKNOWN

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
RESIDENCE	7244 STRATTON WAY, BALTIMORE, MD.

29a. Certifier (Check only one)
1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Theodore M. King	O.C.M.E.	AUGUST 11, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
THEODORE M. King 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
AUG 13 1999	Bonnie D. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

a Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

Amended 4a,per DR, Film G774,dhb,8/12/99

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25502

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mildred Ann Morris

2. Date of Death: Month: August; Dey: 8; Year: 1999

3. Time of Death: 9:15am

4a. Facility Name (If not institution, give street and number): 208 N. Fremont Ave, Apt 3

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

Funeral Director

5. Social Security Number: 212-34-1767

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 65 Yrs.

If Under 1 Year: Months; Days

If Under 24 Hrs.: Hours; Min.

8. Date of Birth (Month, Day, Year): Jun 17,1934

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 208 N. Fremont Ave., Apt. 3

10f. Zip Code: 21201

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Nurse Assistant

16b. Kind of Business/Industry: Hospital

17. Father's Name (First, Middle, Last): Nathaniel Walter Brooks

18. Mother's Name (First, Middle, Maiden Surname): Helen Rosetta Alexander

19a. Informant's Name/Relationship (Type, Print): Walter Eugene Morris (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1557 Claridge Road, Baltimore, MD 21217

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): King Memorial Park

Date: Aug 12 1999

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Calvin L. Williams

22. Name and Address of Facility: Smith & Williams Funeral Home, P.A. 2818 East Baltimore Street, Baltimore, MD

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac Arrest, secondary to probably Angina.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Peptic Ulcer disease.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Hawani Temesgen MD

29c. License number: D46576

29d. Date signed (Month, Day, Year): 8/10/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): HAWANI TEMESGEN 1501 DIVISION STREET, BALTIMORE, 21217.

State Registrar

31. Date filed (Month, Day, Year): AUG 13 1999

32. Registrar's Signature: G. Sparks

AH3

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25503

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Shirley M. Neibuhr
2. Date of Death Month / Day / Year: 8/9/99
3. Time of Death: 2:00 PM
4a. Facility Neme *(If not institution, give street and number)*: 1307 Grand View Court
4b. City, Town, or Location of Death: Fallston
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 216-34-2858
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 61 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: August 12, 1937
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. Stete: MD
10b. County: Harford
10c. City, Town or Location: Fallston
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1307 Grand View Court
10f. Zip Code: 21047
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indien, Black, White, etc. *Specify:* white,

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Sales
16b. Kind of Business/Industry: Retail

17. Fether's Neme *(First, Middle, Last)*: Edward Rottman
18. Mother's Neme *(First, Middle, Maiden Surname)*: Eileen Horn

19e. Informant's Neme/Reletionship *(Type, Print)*: Henry Neibuhr - husband
19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1307 Grand View Court, Fallston, MD 21047

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Meadowridge Memorial Park
Date: 8/12/99
20c. Location - City or Town, State: Elkridge, Maryland

21. Signeture of Funeral Service Licensee: [signature]
22. Neme end Address of Facility: Gary L. Kaufman Funeral Home at Meadowridge Memorial Park 7250 Washington Boulevard, Elkridge, Maryland 21075

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cerdiac or respiretory arrest, shock, or heert feilure. List only one cause on eech line. — Approximate Interval Between Onset and Death

Immediete Cause (Final diseese or condition resulting in death)
a. metastatic lung cancer
Due to (or as a consequence of):

Sequentielly list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or injury thet initiated events resulting in deeth) Last
b.
Due to (or es a consequence of):
c.
Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.
D.M.
Renal failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Wes an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Deeth *(Check only one)*: Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Dete of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end manner steted.

29b. Signeture and title of certifier: [signature]
29c. License number: D37612
29d. Date signed *(Month, Day, Year)*: 8/10/99

30. Neme end address of person who completed causa of death (Item 23a) (Type, Print): Mt Alabrash, MD 1201 Agora Drive, 2c Bel Air MD 21014

State Registrar

31. Dete filed *(Month, Day, Year)*: AUG 13 1999
32. Registrer's Signeture: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25504

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Glady S Neal

2. Date of Death Month Day Year: August 16, 1999

3. Time of Death: 6200 P.M.

4a. Facility Name (If not institution, give street and number): Bon Secours Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-16-4693

8. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 77 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 25, 1921

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1631 Ruxton Ave.

10f. Zip Code: 21216

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Domestic

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Walter Johnson

18. Mother's Name (First, Middle, Maiden Surname): Mary Allen

19a. Informant's Name/Relationship (Type, Print): Mrs. Eleanor Burwell (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2316 W. North Ave. Balto, Md. 21216

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Maryland National

Date: 8/14/99

20c. Location - City or Town, State: Laurel, Md.

21. Signature of Funeral Service Licensee: Joseph L. Russ

22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto, Md. 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cardiac Arrhythmia	Years
Due to (or as a consequence of):	b. Congestive Heart Failure Chronic	5 Years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consequence of): c. End Stage Cardiomyopathy	5 Years
	Due to (or as a consequence of): d. Renal Failure	3 Years

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Pulmonary Hypertension

Rheumatic Valvular Heart Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Larry S. Perry MD

29c. License number: D22031

29d. Date signed (Month, Day, Year): 8-10-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Larry S. Perry MD 2116 Maryland Ave. Balto. Md. 21218

State Registrar

31. Date filed (Month, Day, Year): AUG 13 1999

32. Registrar's Signature: G. Sparks

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

AH3

DHMH 16 Rev 6/95

99-4608-510
B.K.S
DELOIS PRICE AMEND ITEMS: #23 PART I, II, 27 PER MEO G/74 8-26-99 WR

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25505

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DELOIS PRICE
2. Date of Death (Month, Day, Year): AUG. 8, 1999
3. Time of Death: 0655 AM
4a. Facility Name (If not institution, give street and number): BON SECOUR HOSPITAL E.R.
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-74-9935
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 40 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): DECEMBER 8, 1958
9. Birthplace (State or Foreign Country): NORTH CAROLINA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1733 POPLAR GROVE STREET
10f. Zip Code: 21216
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12TH GRADE
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): NURSE AID
16b. Kind of Business/Industry: NURSING HOME

17. Father's Name (First, Middle, Last): ROLAND PRICE SR.
18. Mother's Name (First, Middle, Maiden Surname): VIRGINIA VINCENT

19a. Informant's Name/Relationship (Type, Print): GLWEN PRICE (SISTER-IN-LAW)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10205 SUNNYLAKE A, APT. D, COCKEYSVILLE, MD 21030

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MT. ZION CEMETERY
Date: 08-16-1999
20c. Location - City or Town, State: LANSDOWNE, MARYLAND

21. Signature of Funeral Service Licensee: ▶ Joseph H. Brown
22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVENUE, BALTIMORE, MD 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. CARDIAC ARRYTHMIA DUE TO MYOCARDIAL FIBROSIS	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: DRUG USE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Theodore M. King M.D.
29c. License number: O.C.M.E
29d. Date signed (Month, Day, Year): AUG. , 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): AUG 13 1999
32. Registrar's Signature: B. Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25506

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Martha Palasik

2. Date of Death: Month August Day 6 Year 1999

3. Time of Death: 1:35 AM

4a. Facility Name (If not institution, give street and number): Frederick Villa Nursing Center

4b. City, Town, or Location of Death: Catonsville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-09-4025

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 16 1916

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 711 Academy Road

10f. Zip Code: 21228

10g. Citizen of Whet Country?: USA

11. Marital Stetus: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - Americen Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 7th | College (1-4or 5+):

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Office Worker

16b. Kind of Business/Industry: Western Electric

17. Father's Neme (First, Middle, Last): John Palasik

18. Mother's Name (First, Middle, Meiden Surneme): Carrie Wisniswski

19a. Informent's Name/Reletionship (Type, Print): Melvin Palasik / nephew

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code): 2 Woods Court Baltimore Md. 21221

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Holy Rosary Cemetery Dete: 8/7/99

20c. Location - City or Town, Stete: Baltimore Md.

21. Signeture of Funeral Service Licensee: R. Terry Connelly

22. Neme end Address of Fecility: Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximete Intervel Between Onset end Deeth

Immedlete Ceuse (Finel diseese or condition resulting in death): a. Acute Coronary

Due to (or as a consequence of): ASCVD

Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Lest:

b. Due to (or as a consequence of):

c. Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I: Ca- of colon

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings aveileble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes cese referred to medical exeminer? 1☐ Yes 2☑ No

26. Piece of Deeth (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred et the time, dete end piece, end due to the ceuse(s) end menner as steted. 2☐ **Medical Examiner:** On the basis of exemination end/or investigetion, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: Joseph D. Mc Cosco M.D.

29c. License number: D-19528

29d. Dete signed (Month, Day, Year): 8/10/99

30. Neme end edress of person who completed cause of death (Item 23e) (Type, Print): 5411 Old Frederick Road

State Registrar

31. Dete filed (Month, Day, Year): AUG 13 1999

32. Registrer's Signeture: Jennie G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25507

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): August J. Pencek Jr.

2. Date of Death (Month, Day, Year): August 9, 1999

3. Time of Death: 7:45 P.M.

4a. Facility Name (If not institution, give street and number): 6917 Ebenezer Road

4b. City, Town, or Location of Death: Middle River

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-26-2760

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 75 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): August 17, 1923

9. Birthplace (State or Foreign Country): Maryland

Usual Residance of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Middle River

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 6917 Ebenezer Road

10f. Zip Code: 21220

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 7

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Driver

16b. Kind of Business/Industry: Oil Company

17. Father's Name (First, Middle, Last): August J. Pencek, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Mary Mikolon

19a. Informant's Name/Reletionship (Type, Print): Irene Pencek (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6917 Ebenezer Road, Baltimore, Maryland 21220

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Ebenezer U.M.C. Cemetery

Date: 8/12/99

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: John W. Burkowske

22. Name and Address of Facility: Bruzdzinski Funeral HOme, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Panding investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D21242

29d. Date signed (Month, Day, Year): August 10, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GREGORY KELLY 4109 TIVERTON RD RANDALLSTOWN, MD

State Registrar

31. Date filed (Month, Day, Year): AUG 13 1999

32. Registrar's Signature: Dawn D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

WRC
994098-045
ROBERT C PARKS

AMEND ITEMS: 23 PART I PER MEO G777 11-20-99 WR
AMEND#16,20a,21,&22 PER F.H. G774 J.A. 8-13-99

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25508

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Robert C. Parks, Jr.
2. Date of Death (Month, Day, Year): JULY 13, 1999
3. Time of Death: 10:30 AM.
4a. Facility Name (If not institution, give street and number): 221 BROAD ST. APT 5
4b. City, Town, or Location of Death: SALISBURY
4c. County of Death: Wicomico

Funeral Director

5. Social Security Number: 219-44-3789
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 50 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 21, 1948
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Wicomico
10c. City, Town or Location: Salisbury
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 221 Broad Street, #5
10f. Zip Code: 21801
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: Vietnam
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4or 5+): 3
18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Counselor
16b. Kind of Business/Industry: Student Counseling

17. Father's Name (First, Middle, Last): Robert Parks, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Eva Jean ~~Goldsmith~~ HOLTZMAN

19a. Informant's Name/Relationship (Type, Print): Natasha Parks/daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1427 Beason Street, #1, Baltimore, MD 21230

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] ~~Other (Specify)~~ in state
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory, Inc. — Date: 08/09/99
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: DAWN F. MCDONALD Ronald S. Wade, Director
22. Name and Address of Facility: CREATION SOCIETY OF MARYLAND INC. ~~State Anatomy Board, 655 W. Baltimore Street~~ ~~Baltimore, MD 21201~~ 299 FREDERICK RD. BALTIMORE, MD. 21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. CARDIAC ARRHYTHMIA
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: b. — Due to (or as a consequence of): c. — Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: SCHIZOPHRENIA

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown
24a. Was an autopsy performed? ~~1 [X] Yes~~ 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. Manner of Death: [X] 1 Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Dennis J. Chute
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): JULY 14, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dennis J. Chute, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): AUG 13 1999
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25509

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JAMES CHARLES RICHARD

2. Date of Death: Month AUGUST Day 7th Year 1999

3. Time of Death: 4 PM.

4a. Facility Name (If not institution, give street and number): STELLA MARIS AT MERCY

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/D

Funeral Director

5. Social Security Number: 215-56-5014

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 47 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): OCT 19 1951

9. Birthplace (State or Foreign Country): KANSAS

Usual Residence of Decedent

10a. State: Maryland

10b. County: BALTIMORE

10c. City, Town or Location: OWINGS MILLS

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 201 RIVER WAY COURT

10f. Zip Code: 21117

10g. Citizen of What Country? USA

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th Grade

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOUSE KEEPING

16b. Kind of Business/Industry: HARBOR HOSPITAL

17. Father's Name (First, Middle, Last): JAMES RICHARD

18. Mother's Name (First, Middle, Maiden Surname): VELMA DAVIS

19a. Informant's Name/Relationship (Type, Print): TYRONE DAVIS NEPHEW

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 702 NOTTINGHAM ROAD BALTIMORE, Md 21229

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other piece): ARBUTUS MEMORIAL PARK

Date: 8/13/99

20c. Location - City or Town, State: ARBUTUS, Md

21. Signeture of Funeral Service Licensee: Terry Davis

22. Name and Address of Facility: CHAPMAN-DAVIS F.H. 5240 REISTERSTOWN ROAD BALTIMORE, MD 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Renal Cell Cancer

Due to (or as a consequence of):

Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of ceuse of death? 1 ☐ Yes 2 ☐ No

25. Was cese referred to medicel exeminer? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospice

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D40854

29d. Dete signed (Month, Day, Year): 8/8/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David Rusbasan, MD 301 St Paul Pl Baltimore 21202

State Registrar

31. Dete filed (Month, Day, Year): AUG 13 1999

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified as soon.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

AFI

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25510

20a
AMEND#20b&20c PER CMTRY G774 8-13-99 J.A.

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mattie Ratliff

2. Date of Death: Month 08 Day 06 Year 1999

3. Time of Death: 12:02 p.m.

4a. Facility Name (If not institution, give street and number): Harbor Hospital Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-12-7490

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 12 25 1918

9. Birthplace (State or Foreign Country): South Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel Co.

10c. City, Town or Location: N/A

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 216 Elizabeth Avenue

10f. Zip Code: 21225

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Domestic

16b. Kind of Business/Industry: Self-employed

17. Father's Name (First, Middle, Last): William Richards

18. Mother's Name (First, Middle, Maiden Surname): Lugenia Miles

19a. Informant's Name/Relationship (Type, Print): Adrienne Pinder/Grandaughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 216 Elizabeth Ave. Baltimore, Maryland 21225

20a. Method of Disposition: 1☐ Burial 2☒ ~~Cremation~~ 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): ~~Metro Crematory~~ MT. ZION CEMETERY

Date: ~~8/13/99~~ 8/14/99

20c. Location - City or Town, State: ~~Catonsville, Md.~~ BALTIMORE, MD.

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: William C. Brown Community Funeral Home 1206 W. North Avenue, Baltimore, Maryland 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardiac Dysrhythmia — Mins.

Due to (or as a consequence of):
b. Atherosclerotic Cardiovascular Disease — 20 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus - Type II

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and menner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end piece, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: [signature] Robert Dart Jr. MD

29c. License number: D39660

29d. Date signed (Month, Day, Year): August 12, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert C Dart Jr 901 E. Fort Ave. Baltimore MD 21230

State Registrar

31. Date filed (Month, Day, Year): AUG 13 1999

32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

MS CATE.

AHB

ORIGINAL

99-4593-510

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25511

JAMES RAIMEY AMEND#8 PER F.H. G774 8-13-99 J.A.

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
James M. Raimey	Aug. 7, 1999	4:45AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SINAI HOSPITAL E.R.	BALTIMORE	None

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-58-7159	1☒ M 2☐ F	48 Yrs.			July 7, ~~1999~~ 1951	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	None	Baltimore	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3320 Dorithan Rd.	21215	USA

11. Meritel Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Drapery Installer	Self Employed

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
James E. Raimey	Helen McGruder

19a. Informent's Neme/Reletionship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Jason Raimey/Son	4011 Hilton Rd. Baltimore, Maryland 21215

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other place)	Date	20c. Location - City or Town, Stete
1☒ Buriel 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)	Mt. Zion	8-16-99	Landsdowne, Maryland

21. Signature of Funeral Service Licensee: Derrick C. Jones

22. Name end Address of Facility: The Derrick C. Jones Funeral Home 4611 Park Heights Ave. Baltimore, Maryland 21215

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, euch es cardiac or respiratory arrest, shock, or heert feilure. List only one ceuse on each line.

		Approximate Interval Between Onset and Death
Immediete Cause (Finel diseese or condition resulting in deeth)	a. Narcotic Intoxication in association with [illegible]	
Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last	b. Atherosclerotic Cardiovascular Disease	
	Due to (or es e consequence of):	
	c.	
	Due to (or es a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performed?	24b. Were autopsy findings aveilable prior to completion of cause of death?
1☒ Yes 2☐ No	1☒ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☒ Could not be determined	8/7/99	Unknown M	1☐ Yes 2☒ No	Unknown

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify): home

28f. Location (Street and Number or Rural Route Number, City or Town, Stete): 3320 Dorthian Rd., Balto. City, Md.

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) end manner as steted. 2☒ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted.

29b. Signeture end title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
J Pestaner, M.D.	O.C.M.E.	August 7, 1999

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Joseph P. Pestaner, M.D. 111 Penn Street, Baltimore, MD. 21201

State Registrar

31. Dete filed (Month, Dey, Year)	32. Registrer's Signeture
AUG 13 1999	Brenda B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

AM 1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25512

AMENDED ITEM #16a PER FH G774 8/13/99 AH

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JAMES EDWARD SMITH, JR.

2. Date of Death (Month, Day, Year): August 7, 1999

3. Time of Death: 10:40A

4a. Facility Name (If not institution, give street and number): 9219 TURNBULL ROAD

4b. City, Town, or Location of Death: RANDALLSTOWN

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 219-42-5309

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 55 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Apr. 16, 1944

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: Maryland

10b. County: BALTIMORE

10c. City, Town or Location: RANDALLSTOWN

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 9219 TURNBULL ROAD

10f. Zip Code: 21133

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th grade

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): PHYSICAL THERAPY AIDE ~~Physical Therapy Aide~~

16b. Kind of Business/Industry: MONTEBELLO/KENNEDY HOSPITAL

17. Father's Name (First, Middle, Last): JAMES E. SMITH, SR.

18. Mother's Name (First, Middle, Maiden Surname): BERTHA M. BESS

19a. Informant's Name/Relationship (Type, Print): PAULA SMITH / WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9219 TURNBULL ROAD RANDALLSTOWN, MD 21133

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): DULANEY VALLEY MEMORIAL GARDENS Date: 8/11/99

20c. Location - City or Town, State: TOWSON, MARYLAND

21. Signature of Funeral Service Licensee: Gary Harris

22. Name and Address of Facility: CHATHAM - HARRIS FUNERAL HOME 5240 REISTERSTOWN ROAD BALTIMORE MARYLAND 21215

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC COLON CANCER — YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Richard A. O'Malley MD

29c. License number: D0047625

29d. Data signed (Month, Day, Year): 8/9/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RICHARD A. O'MALLEY, MD 7600 OSLER DRIVE, SUITE 311. TOWSON, MD 21204

State Registrar

31. Date filed (Month, Day, Year): AUG 13 1999

32. Registrar's Signature: Bonnie G. Sparks

AH 11

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

RKD

99-4665-027

ANDREA SIMONSON

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25513

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Andrea Kelly Simonson

2. Data of Death — Month: AUGUST Day: 11 Year: 1999

3. Time of Death: 5:00P.M.

4a. Facility Name (If not institution, give street and number): WEST BOUND I 70

4b. City, Town, or Location of Death: WOODBINE

4c. County of Death: HOWARD

Funeral Director

5. Social Security Number: 594-56-9926

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 18 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): July 2, 1981

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Essex

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1001 East Homberg Avenue

10f. Zip Code: 21221

10g. Citizen of What Country?: U.S.A.

11. Marital Status: ☒1 Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes ☒2 No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes ☒2 No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4 or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Student

16b. Kind of Business/Industry: School

17. Father's Name (First, Middle, Last): Richard W. Simonson

18. Mother's Name (First, Middle, Maiden Surname): Dorothy Hodge

19a. Informant's Name/Relationship (Type, Print): Dorothy Mitchell (mother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1001 East Homberg Avenue, Baltimore, Maryland 21221

20a. Method of Disposition: ☒1 Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Sacred Heart of Jesus

Date: 8/14/99

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: John W. Burkowske

22. Name and Address of Facility: Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Multiple Injuries

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes ☒2 No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? ☒1 Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? ☒1 Yes 2☐ No

25. Was case referred to medical examiner? ☒1 Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence ☒6 Other (Specify) SCENE

27. Manner of Death: 1☐ Natural ☒2 Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year): 8/11/99

28b. Time of Injury: 1658 M

28c. Injury at Work? 1☐ Yes ☒2 No

28d. Describe how injury occurred: Driver Struck by Vehicle

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Highway

28f. Location (Street and Number or Rural Route Number, City or Town, State): I-70 (mile mark 70-71)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☒2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John Lake MD

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): AUGUST 12, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): John Lake, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): AUG 13 1999

32. Registrar's Signature: L. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25514

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Gulseren, Suner
2. Date of Death: Month August, Day 12, Year 1999
3. Time of Death: 13:05
4a. Facility Name (If not institution, give street and number): Johns Hopkins Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: N/A
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 67 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): April 8, 1932
9. Birthplace (State or Foreign Country): Turkey

Usual Residence of Decedent

10a. State: Turkey
10b. County: N/A
10c. City, Town or Location: Istanbul
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 63 Noter Street Apt 6
10f. Zip Code: N/A
10g. Citizen of What Country? Turkey

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Edip Benhesavi
18. Mother's Name (First, Middle, Maiden Surname): Emine Unknown

19a. Informant's Name/Relationship (Type, Print): Ali Sedat Suner - Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 34 Kazimsil Ivili Street Block 3 Yesilkoy, Istanbul, Turkey

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Cemetery of Istanbul, Turkey
Date: 8/19/99
20c. Location - City or Town, State: Istanbul, Turkey

21. Signature of Funeral Service Licensee: Joseph N. Zannino Jr.
22. Name and Address of Facility: Joseph N. Zannino Jr. Funeral Home, 263 S. Conkling Street Balto. MD 21224

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	thromboembolic stroke	24 hours
Due to (or as a consequence of): b.	atherosclerotic disease	10 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last. Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: coronary artery disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Patty Chi MD
29c. License number: RES-000
29d. Date signed (Month, Day, Year): August 12, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Patty Chi MD, Johns Hopkins Hospital 600 N. Wolfe Street Balti. MD 21287

State Registrar

31. Date filed (Month, Day, Year): AUG 16 1999
32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25515

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Carolyn Sue Stohl	August 5 1999	9:31PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Franklin Square Hospital Center	Rosedale	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-74-8617	1☐ M 2☒ F	41 Yrs.			MAY 18, 1958	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Baltimore	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1105 Old Eastern Ave., Apt. A	21221	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	2	Homemaker	Domestic

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Harry Gladstone Keller	Rita Mae Myers

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
David Stohl, Sr./husband	1105 Old Eastern Ave. Apt. A Baltimore, MD 21221

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Metro Crematory, Inc.	08/11/99	Baltimore, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Dawn F. McDonald	Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Morbid obesity	years
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Sepsis secondary perforation of Transverse Colon

Pelvic Abcess

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒ Yes 2☐ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	196592 RD	8/5/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Dr. Huzefa Bahrain 9000 Franklin Square Drive Baltimore, Maryland 21237

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
AUG 13 1999	George B. Hoaks

DHMH 16 Rev 6/95

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Stohl, Carolyn

AHS

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25516

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): George Surincheck
2. Date of Death (Month, Day, Year): AUG 11, 1999
3. Time of Death: 8:25am
4a. Facility Name (If not institution, give street and number): Oaklodge Assisted Living
4b. City, Town, or Location of Death: Pasadena
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 112-12-5625
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 91 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MAR 25, 1908
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Pasadena
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 7753 Outing Avenue
10f. Zip Code: 21122
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Longshoreman
16b. Kind of Business/Industry: Port of Baltimore

17. Father's Name (First, Middle, Last): Stephan Surinchak
18. Mother's Name (First, Middle, Maiden Surname): Mary Lasky

19a. Informant's Name/Relationship (Type, Print): Paul D. Semanko/nephew
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 240 A Edgemont Ave. Ardmore, PA 19003

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory, Inc. | Date: 8/12/99
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Dawn F. McDonald
Dawn F. McDonald
22. Name and Address of Facility: Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. RENAL FAILURE
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. MYOCARDIAL INFARCTION
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Patel MD
29c. License number: D37111
29d. Date signed (Month, Day, Year): 8/11/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): P. PATEL 606 HAMMONDS LN BALTIMORE MD 21225

State Registrar

31. Date filed (Month, Day, Year): AUG 13 1999
32. Registrar's Signature: Barbara G. Sparks

AH 7

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25517

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: LETHA MAY SIEGMUND

2. Date of Death — Month: AUGUST Day: 10 Year: 1999

3. Time of Death: 1800

4a. Facility Name *(If not institution, give street and number)*: CHURCH HOME NURSING CENTER

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-24-3877

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 70 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Date of Birth *(Month, Day, Year)*: Jan. 7, 1929

9. Birthplace *(State or Foreign Country)*: W. VIRGINIA

Usual Residence of Decedent

10a. State: MD.

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 215 S. WASHINGTON STREET

10f. Zip Code: 21231

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6 College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: TEACHER'S AIDE

16b. Kind of Business/Industry: BALTO. CITY SCHOOLS

17. Father's Name *(First, Middle, Last)*: JOHN S. WILSON

18. Mother's Name *(First, Middle, Maiden Surname)*: SALLY N. HOSE

19a. Informant's Name/Relationship *(Type, Print)*: CATHY SCHAFFER/DAUGHTER

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2650 CAPE HORN ROAD, WESTMINSTER, MD. 21157

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: HOLY REDEEMER CEMETERY Date: 8/14/99

20c. Location - City or Town, State: BALTIMORE, MD.

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: LILLY & ZEILER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MD. 21231

To Be Completed by Funeral Director

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. LUNG CANCER — YEAR

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: OBSTRUCTIVE PULMONARY DISEASE, CHRONIC ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29e. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] Med-Specialist

29c. License number: D 40356

29d. Date signed *(Month, Day, Year)*: AUGUST 10 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): WENELISA NAVARRO, MD. 100 N. BROADWAY, BALTIMORE, MARYLAND 21231

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 13 1999

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

LETHA SIEGMUND

AH 11

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25518

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Michael Joseph Schlereth

2. Date of Death — Month: August; Day: 10; Year: 1999

3. Time of Death: 3:58 A.M.

4a. Facility Name *(If not institution, give street and number)*: 1537 Ramsey Street

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218 62 9917

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 37 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec. 28, 1961

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 1537 Ramsey Street

10f. Zip Code: 21223

10g. Citizen of What Country?: U.S.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yas 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Manager

16b. Kind of Business/Industry: Tavern

17. Father's Name *(First, Middle, Last)*: Philip Offenbacher

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Schlereth

19a. Informant's Name/Relationship *(Type, Print)*: Louise Schlereth / wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1537 Ramsey Street Baltimore, Maryland 21223

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Holy Cross Cemetery

Date: 8/13/99

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Jerome Gonce

22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. GLIOBLASTOMA MULTIFORME — 3 YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Diana H. Griffiths

29c. License number: D0019419

29d. Date signed *(Month, Day, Year)*: August 10, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DIANA H. GRIFFITHS 900 CATON AVE, BALTIMORE, MD, 21229

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 13 1999

32. Registrar's Signature: Gregory D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: #7 PER F.H. G774 8-13-99 WR.

Certificate of Death

Reg. No. 99 25519

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: DOROTHY B. UNDERWOOD

2. Date of Death: Month AUGUST Day 9th Year 1999

3. Time of Death: 12:30 Am

4a. Facility Name *(If not institution, give street and number)*: BON SECOURS HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-48-9566

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs, last birthday)*: 73 ~~63~~ Yrs. If Under 1 Yaar: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Yaar)*: APRIL 27, 1926

9. Birthplaca *(State or Foraign Country)*: VIRGINIA

Usual Residenca of Decedent

10a. State: MARYLAND

10b. County: N/A

10c. City, Town or Location: BALTIMORE CITY

10d. Insida City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3511 WEST FRANKLIN STREET

10f. Zip Code: 21229

10g. Citizen of What Country?: USA.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Detas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, atc. *Specify:* BLACK

15. Decedent's Education *(Specify only highast grada complatad)*: Elementary/Secondary (0-12): 12TH GRADE; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa retired)*: HOMEMAKER

16b. Kind of Business/Industry: OWN HOME

17. Father's Name *(First, Middla, Last)*: WELDON JACKSON

18. Mother's Name *(First, Middla, Maidan Surnama)*: ROSE WELDON

19a. Informant's Name/Relationship *(Type, Print)*: FRANCINE UNDERWOOD (DAUGHTER)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stata, Zip Code)*: 4515 FAIRVIEW AVE., APT C, BALTIMORE MD. 21216

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Placa of Disposition *(Nama of cematary, cramatory or othar placa)*: GARRISON FOREST CEME. Date: 08-16-99

20c. Location - City or Town, State: OWINGS MILLS, MD.

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE. BALTIMORE, MD. 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that causad tha daath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Finat disease or condition resulting in death): a. Metastatic Lung CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in death) Last:

b. Due to (or as a consequenca of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only ona)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, streat, factory, offica building, etc. *(Specify)*

28f. Location *(Straat and Numbar or Rural Routa Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end piece, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the besis of examinetion end/or investigation, in my opinion, death occurred at the time, date and pleca, and due to the cause(s) and manner stated.

29b. Signature and title of cartifier: ▶ Terance L. Lamb M.D

29c. Licansa number: D37203

29d. Data signed *(Month, Day, Year)*: AUGUST 9th 1999

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print): Terance LAMB Bon Secours Hospital, Baltimore md. 21223

State Registrar

31. Date filed *(Month, Day, Yaar)*: AUG 13 1999

32. Registrar's Signature: ▶ [signature] G. Sparks

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Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that tha death certificate be executed within 24 hours after death.
To the Funeral Director: Aftar this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

AHY

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25520

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MYRTLE CAROLINE VIRGIN
2. Date of Death (Month, Day, Year): AUGUST 11, 1999
3. Time of Death: 2:05 PM
4a. Facility Name (If not institution, give street and number): MILLENNIUM SOUTH RIVER
4b. City, Town, or Location of Death: EDGEWATER
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 215-05-9720
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Dey, Year): JULY 30, 1915
9. Birthplace (State or Foraign Country): MARYLAND

Usual Residenca of Decedent

10a. State: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: EDGEWATER
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 144 WASHINGTON ROAD
10f. Zip Code: 21037
10g. Citizen of What Country?: U.S.A.

To Be Completed by Funeral Director

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highast grada complatad): Elementary/Secondary (0-12): 6 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME
17. Father's Name (First, Middle, Last): ARTHUR SLAGLE
18. Mother's Neme (First, Middla, Maidan Surname): IDA GREGORY
19a. Informant's Name/Relationship (Type, Print): MILDRED L. ARNOLD (DAUGHTER)
19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Steta, Zip Code): 8624 PA HARRY DRIVE, CHAMBERSBURG, PA. 17201
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Piece of Disposition (Nema of camatary, cramatory or othar placa): CEDAR HILL CEMETERY
Date: 8/13/99
20c. Location - City or Town, Stata: BROOKLYN PARK, MD.
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease or complications that caused the daath. Do not enter tha mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on eech line. (Approximate Interval Between Onsat and Death)

Immediete Ceuse (Final disaase or condition resulting in death)
a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE — YRS
Due to (or as a consequence of):
b. HYPERTENSION — YRS
Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other aignificant conditions** contributing to death but not resulting in the underlying cause given in Part I.: RENAL INSUFFICENCY

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Chack only one): Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Spacify)
28f. Location (Straat and Number or Rural Routa Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, dete and place, and due to the ceuse(s) end manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, snd due to the cause(s) end manner stated.

29b. Signature and title of certifier: [signature] MD
29c. Licansa number: D20333
29d. Data signed (Month, Day, Year): 8/12/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): K. ZONIES MD 438 LANCASTER AD PIKESVILLE MD

State Registrar

31. Date filed (Month, Day, Year): AUG 13 1999
32. Registrar's Signature: [signature]

To be completed by the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM :# 26 PER MD G774 8-13-99 WR.

Certificate of Death

Reg. No. 99 25521

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
THERESA	FRANCES	VINEYARD	AUGUST 10, 1999	10:00 P.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
314 VALIANT CIRCLE	GLEN BURNIE	ANNE ARUNDEL

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-70-3600	1☐M 2☒F	40 Yrs.			OCT. 12, 1958	MARYLAND

Usual Residance of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	TALBOT	McDANIEL	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
9801 TILGHMAN ISLAND ROAD	21647	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	3	BOOKKEEPER	TATTOO PARLOR

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
BOBBIE POMPANIO	JOANN SHIRLEY TIMLIN

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
HUGH VINEYARD, JR. (HUSBAND)	9801 TILGHMAN ISLAND ROAD, McDANIEL, MD. 21647

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	GLEN HAVEN MEMORIAL PARK	8/14/99	GLEN BURNIE, MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Michael C. Goffigan	SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

Physician /Medical Examiner

23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Lung Carcinoma — 6 months
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) MOTHER'S RESIDENCE

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
MD	D38958	8/11/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Darjeet Singh Sidhu 1413 Annapolis Road #106 odenton MD 21113

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
AUG 13 1999	Renee G. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28d show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25522

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ruth Newman Vice
2. Date of Death (Month, Day, Year): August 12 1999
3. Time of Death: 5-08AM
4a. Facility Name (If not institution, give street and number): North Arundel Hospital
4b. City, Town, or Location of Death: Glen Burnie
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 214-44-4748
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 25, 1921
9. Birthplace (State or Foreign Country): Kentucky

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Glen Burnie
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 527 Newfield Road
10f. Zip Code: 21061
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher
16b. Kind of Business/Industry: Education

17. Father's Name (First, Middle, Last): Ben Frank Newman
18. Mother's Name (First, Middle, Maiden Surname): Elsie Burchell

19a. Informant's Name/Relationship (Type, Print): Cline L. Vice/Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 527 Newfield Road Glen Burnie, MD 21061

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Glen HAven Mem. Pk. | Date: Aug. 15, 1999
20c. Location - City or Town, State: Glen Burnie, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Kirkley-Ruddick Funeral Home P.A. 421 Crain Hwy. S.E. Glen Burnie, MD 21061

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart feilure. List only one cause on eech line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	CARDIOGENIC SHOCK	8 DAYS
Due to (or as a consequence of):		
b.	ACUTE MYOCARDIAL INFARCTION	8 DAYS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D46962
29d. Date signed (Month, Day, Year): AUGUST 12, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): M. SHIRAZI, MD. NORTH ARUNDEL HOSPITAL, MD 21061.

State Registrar

31. Date filed (Month, Day, Year): AUG 13 1999
32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25523

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Allen Wells
2. Date of Death: Month 8 Day 11 Year 99
3. Time of Death: 15:55
4a. Facility Name (If not institution, give street and number): University of Maryland Medical Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-38-2869
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 57 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): NOV. 12, 1941
9. Birthplace (State or Foreign Country): FLORIDA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 528 SOUTH PACA STREET
10f. Zip Code: 21230
10g. Citizen of What Country?: USA.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 TH GRADE; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SHOE REPAIR SALESMAN
16b. Kind of Business/Industry: SHOE STORE

17. Father's Name (First, Middle, Last): ARRIE WELLS
18. Mother's Name (First, Middle, Maiden Surname): RUBY MAE WILLIAMS

19a. Informant's Name/Relationship (Type, Print): RUBY BAXTER (SISTER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3626 DOLFIELD AVENUE, BALTIMORE, MD. 21215

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MT. ZION CEMETERY
Date: 8-14-99
20c. Location - City or Town, State: LANSDOWNE, MARYLAND

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTIMORE, MD. 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Large Bowel Obstruction — 2 weeks
Due to (or as a consequence of):
b. Colon Cancer — 2 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: William C. Chiu, M.D.
29c. License number: D46147
29d. Date signed (Month, Day, Year): 8/11/99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William C. Chiu, M.D., 22 South Greene Street, Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year): AUG 13 1999
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

A18

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25524

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John E. Wilson
2. Date of Death: Month August Day 06 Year 1999
3. Time of Death: 2330
4a. Facility Name (If not institution, give street and number): Sinai Hospital of Baltimore
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore city

Funeral Director

5. Social Security Number: 250-03-0057
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 15, 1916
9. Birthplace (State or Foreign Country): South Carolina

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 5013 PIMLICO ROAD
10f. Zip Code: 21215
10g. Citizen of What Country? USA.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11TH GRADE | College (1-4or 5+)
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): STATIONARY ENGINEER
16b. Kind of Business/Industry: BALTO. CO. PUBLIC SCHOOLS

17. Father's Name (First, Middle, Last): JESSIE WILSON
18. Mother's Name (First, Middle, Maiden Surname): MARETTA HILTON

19a. Informant's Name/Relationship (Type, Print): AMELIA WILSON (WIFE)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5013 PIMLICO RD, BALTIMORE, MD. 21215

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): KING MEMORIAL PARK
Date: 8-11-99
20c. Location - City or Town, State: WOODLAWN, MARYLAND

21. Signature of Funeral Service Licensee: John L. Williams
22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTIMORE, MD. 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Atherosclerotic Cardiovascular disease	45 minutes
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I: Alzheimer's type Dementia with delusions

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: David L. Shentz, M.D.
29c. License number: D43692
29d. Date signed (Month, Day, Year): August 06, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David L. Shentz, M.D. Sinai Hospital of Balt. 2401 W. Belvedere Ave Balt. Md. 21215

State Registrar

31. Date filed (Month, Day, Year): AUG 18 1999
32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

AH10

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

99 25525

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lillian May Wilkinson

2. Date of Death (Month, Day, Year): August 12, 1999

3. Time of Death: 4:00 AM

4a. Facility Name (If not institution, give street and number): St. Elizabeth Nursing Home

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-10-4730

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 95 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 23, 1904

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 630 Washington Avenue

10f. Zip Code: 21227

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 3rd Grade

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Assembly Line

16b. Kind of Business/Industry: Westinghouse

17. Father's Name (First, Middle, Last): Charles Philip Gehringer

18. Mother's Name (First, Middle, Maiden Surname): Pauline Linsenmeyer

19a. Informant's Name/Relationship (Type, Print): Charles H. Gehringer (Brother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 630 Washington Avenue - Baltimore, Maryland 21227

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Loudon Park Cemetery

Date: 8/14/99

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Juanita R. Thomas

22. Name and Address of Facility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue - Baltimore, Maryland 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Sepsis	48 hours
Due to (or as a consequence of): b.	Large Pre-Sacral Ulcer	2 weeks
Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last. Due to (or as a consequence of): c.	Malnutrition	3 months
Due to (or as a consequence of): d.		

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Multiple Metastatic Facial Skin Cancers

Coronary Heart Disease. Crippling

Degenerative Joint Disease. Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ATTENDING

29c. License number: D16200

29d. Date signed (Month, Day, Year): August 12, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. N. Machiran 720-C Maiden Choice La., Catonsville, MD 21228

State Registrar

31. Date filed (Month, Day, Year): AUG 13 1999

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

AHB

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25526

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ira William Wells
2. Date of Death (Month, Day, Year): 8/11/99
3. Time of Death: 5:58 AM
4a. Facility Name (If not institution, give street and number): Stella Maris
4b. City, Town, or Location of Death: Timonium
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 214-14-8862
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 5/7/1922
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 5143 Terrace Drive
10f. Zip Code: 21236
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Plumber
16b. Kind of Business/Industry: Plumbing

17. Father's Name (First, Middle, Last): Ira William Wells
18. Mother's Name (First, Middle, Maiden Surname): Mary Zeltman

19a. Informant's Name/Relationship (Type, Print): Ernest Wells
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5143 Terrace Drive Baltimore, Maryland 21236

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gardens of Faith Cemetery
Date: 8/14/99
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Martin J. Dippel Jr
22. Name and Address of Facility: Dippel Funeral Home Inc. 7110 Belair Road Baltimore, Maryland 21206

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Rectal Carcinoma

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, data and place, and dua to tha cause(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, data end place, end due to tha cause(s) and manner stated.

29b. Signature and title of certifier: ▶
29c. License number: D43725
29d. Date signed (Month, Day, Year): 8/11/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): TARIQ MAHMOOD 201 Back River Neck Road Baltimore MD 21221

State Registrar

31. Date filed (Month, Day, Year): AUG 13 1999
32. Registrar's Signature: ▶ G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25527

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Hattie Mae Wright

2. Date of Death (Month, Day, Year): August 10, 1999

3. Time of Death: 6:30am

4a. Facility Name (If not institution, give street and number): Rock Glen Nursing & Rehabilitation Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-14-0771

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 84 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec 25, 1914

9. Birthplace (State or Foreign Country): S. Carolina

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1136 North Fulton Avenue

10f. Zip Code: 21217

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 1☐ Yes 2☒ No Specify:

14. Race - Americen Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elamantary/Secondary (0-12): 12th

Collaga (1-4or 5+):

16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife

16b. Kind of Business/Industry: Domestic

17. Father's Name (First, Middle, Last): Dock Jackson

18. Mother's Name (First, Middle, Maiden Surname): Janie Smith

19a. Informant's Name/Relationship (Type, Print): Mable Lewis Cynthia Wright-Rock (Daughters)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3012 Romaric Court Apt. D Baltimore, Md 21209

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Arbutus Memorial Park

Date: 08/16/99

20c. Location - City or Town, State: Arbutus, Maryland

21. Signature of Funeral Service Licensee: [signature] Caple

22. Name and Address of Facility: Caple Funeral Service 5502 Winner Avenue Baltimore, Maryland 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that ceused the daath. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only ona cause on each lina.

Approximata Intarval Batween Onset and Death

Immediate Causa (Final disease or condition resulting in death) a. Acute Myocardial Infarction — hours

Dua to (or as a consaquance of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Wara autopsy findings availabla prior to completion of ceusa of death? 1☐ Yes 2☐ No

25. Was case rafarred to medical examinar? 1☐ Yes 2☑ No

26. Placa of Daath (Check only one) Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA Othar: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Mannar of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Panding Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)

28f. Location (Streat and Number or Rural Route Number, City or Town, State)

29a. Certifiar (Check only one) 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceusa(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner statad.

29b. Signature and title of certifiar: [signature] MD

29c. License number: D-40521

29d. Data signed (Month, Day, Year): August 12, 1999

30. Nama and address of person who complated cause of daath (Item 23a) (Type, Print) DR OCHANEY 7845 Oakwood Road Suite 205 Glen Burnie, MD 21061

State Registrar

31. Datа Filed (Month, Day, Year): AUG 13 1999

32. Registrar's Signature: [signature] B. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

MD CASE

4H15

DHMH 16 Rev 6/95

ADH
JAMES WALKER
99-4634-510

AMEND ITEMS: #23 PART I, 27, 28A-F PER MEO G774 8-23-99 WR

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

99 25528
Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JAMES FRANKLIN WALKER
2. Date of Death (Month, Day, Year): AUGUST 9, 1999
3. Time of Death: 2148 PM
4a. Facility Name *(If not institution, give street and number)*: HARBOR HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-66-4786
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 43 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Aug. 19 1955
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Md.
10b. County: n/a
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 41 E. Heath Street
10f. Zip Code: 21230
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 9; College (1-4or 5+): 0
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Pressman
16b. Kind of Businass/Industry: E. J. Schmidz Company

17. Father's Name *(First, Middle, Last)*: James R. Walker
18. Mother's Name *(First, Middle, Maiden Surneme)*: Madeline H. Bryley

19a. Informant's Name/Relationship *(Type, Print)*: Beth E. Walker (Wife)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 41 E. Heath Street, Baltimore, Md. 21230

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Green Mount Cemetery
Date: 8/13/99
20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: David A. Hayes
22. Name and Address of Facility: McCully-Polyniak Funeral Home P.A. 130 E. Fort Ave., Baltimore, Md. 21230

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disaasa or condition rasulting in death)
a. ACUTE NARCOTIC INTOXICATION
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☒ Could not be determined
28a. Date of Injury *(Month, Day Year)*: UNKNOWN
28b. Time of Injury: UNKNOWN M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: UNKNOWN
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: UNKNOWN
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: UNKNOWN

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the tima, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Dennis J Chuteau
29c. License number: OCME
29d. Date signed *(Month, Day, Year)*: AUGUST 10, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dennis Chuteau 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filed *(Month, Day, Year)*: AUG 13 1999
32. Registrar's Signature: Regina D. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

99-4614-510
CJ
Ellis Wilson

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25529

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ELLIS WILSON, JR.

2. Date of Death: Month August, Day 08, Year 1999

3. Time of Death: 12:43 PM.

4a. Facility Name (If not institution, give street and number): 47 North Catherine Street

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 248 66 7297

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 55 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 9/10/1943

9. Birthplace (State or Foreign Country): SouthCarolina

Usual Residence of Decedent

10a. State: MD.

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 47 N. CATHERINE STREET

10f. Zip Code: 21223

10g. Citizen of What Country?: U.S. OF A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No. If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12TH; College (1-4or 5+): UNKNOWN

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): BODY & FENDER REPAIR MAN

16b. Kind of Business/Industry: AUTO REPAIR SHOP

17. Father's Name (First, Middle, Last): ELLIS WILSON SR

18. Mother's Name (First, Middle, Maiden Surname): GENEVA CAINE

19a. Informant's Name/Relationship (Type, Print): RUTHA M. WILSON (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5408 PEMBROKE AVE. BALTIMORE.MD. 21207

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): GARRISON FOREST VET. CEM. Date: 8/17/99

20c. Location - City or Town, State: OWINGS MILLS, MD. Co. BALTO.

21. Signature of Funeral Service Licensee: LEWIS T. GWYNN — Lewis T. Gwynn

22. Name and Address of Facility: LEWIS T. GWYNN FUNERAL HOME 21215-6393, 4517 PARK HEIGHTS AVE. BALTO.,MD.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA. Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J Pertanen, M.D.

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): August 9, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Pertanen 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): AUG 13 1999

32. Registrar's Signature: Irma G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

AT 671

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEM #9,20b, & 20c PER FH G774 8/24/99 AH

Certificate of Death

Reg. No. 99 25530

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LARRY LEE YATES JR

2. Date of Death: Month August Day 10 Year 1999

3. Time of Death: 6:25 P

4a. Facility Name (If not institution, give street and number): UNIV OF MARYLAND MEDICAL CENTER

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 316-42-0805

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 54 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 5-27-45

9. Birthplace (State or Foreign Country): VIRGINIA ~~South Carolina~~

Usual Residence of Decedent

10a. State: MD

10b. County: BALTIMORE

10c. City, Town or Location: WOODLAWN

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 25 SHERROW COURT

10f. Zip Code: 21244

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): RESERVATION CLERK

16b. Kind of Business/Industry: TRANSPORTATION

17. Father's Name (First, Middle, Last): LARRY LEE YATES SR

18. Mother's Name (First, Middle, Maiden Surname): MARY LEE HARGROVE

19a. Informant's Name/Relationship (Type, Print): MARY LEE YATES MOTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 38 BROOKS TERRACE GLEN BURNIE MD 21060

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): LOUDEN PARK CEMETERY ~~GARRISON FOREST~~ Date: 8-17-99

20c. Location - City or Town, State: BALTIMORE, MD ~~OWINGS MILLS, MD~~

21. Signature of Funeral Service Licensee: Willie E. Howell

22. Name and Address of Facility: 4600 21 BERRY HEIGHTS DRIVE BALTIMORE MD 21207

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. PULMONARY EMBOLUS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. LUNG CANCER

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jeahan MD

29c. License number: #21429

29d. Date signed (Month, Day, Year): Aug 10, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jeahan R. Hanna 22 S. Greene St, Baltimore, Maryland

State Registrar

31. Date filed (Month, Day, Year): AUG 13 1999

32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

AH 6

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 2553

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ANNETTE YOUNG

2. Date of Death: Month: August; Day: 10; Year: 1999

3. Time of Death: 1826 PM

4a. Facility Name *(If not institution, give street and number)*: MERCY MEDICAL CENTER

4b. City, Town, or Location of Death: BALTIMORE, MARYLAND

4c. County of Death: BALTIMORE CITY

Funeral Director

5. Social Security Number: 215-22-2135

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 71 Yrs.

If Under 1 Year: Months; Days

If Under 24 Hrs.: Hours; Min.

8. Date of Birth *(Month, Day, Year)*: Sept. 26, 1927

9. Birthplace *(State or Foreign Country)*: Md.

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Md.

10b. County: n/a

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 319 N. Gilmor Street

10f. Zip Code: 21223

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th Grade; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Food Service Worker

16b. Kind of Business/Industry: Baltimore City Public Schools

17. Father's Name *(First, Middle, Last)*: William Roy Briscoe

18. Mother's Name *(First, Middle, Maiden Surname)*: Jennie Louise Yerby

19a. Informant's Name/Relationship *(Type, Print)*: James Reginald Young son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3305 Mayfair Road Baltimore, Md. 21207

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: King Memorial Park

Date: Aug. 13

20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: Grant R. Fenney

22. Name and Address of Facility: Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. SEPSIS — 2 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Titus Abraham, M.D.

29c. License number: P12359

29d. Date signed *(Month, Day, Year)*: August 10, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): TITUS ABRAHAM, UNIVERSITY OF MARYLAND MEDICAL CENTER 22 SOUTH GREENE ST., BALTIMORE, MD 21201

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 13 1999

32. Registrar's Signature: B. Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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AHO

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25532

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Margaret Zang

2. Date of Death: Month August, Day 10, Year 1999

3. Time of Death: 5:55 pm

4a. Facility Name (If not institution, give street and number): 36835 Danny's Lane

4b. City, Town, or Location of Death: Chaptico

4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 579-14-2580

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): Dec. 27, 1920

9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: MD

10b. County: St. Mary's

10c. City, Town or Location: Chaptico

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 36835 Danny's Lane

10f. Zip Code: 20621

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Louis Benjamin Hagen

18. Mother's Name (First, Middle, Maiden Surname): Myrtle Augusta Phipps

19a. Informent's Name/Relationship (Type, Print): Tippy Buckler (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 36835 Danny's Lane, Chaptico, MD 20621

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Quaker Cemetery

Date: 08/14

20c. Location - City or Town, State: Galesville, MD

21. Signature of Funeral Service Licensee: Thomas A Hardesty

22. Name and Address of Facility: Hardesty Funeral Home,P.A. 12 Ridgely Avenue, Annapolis, MD 21401

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Multiple strokes — 4 yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Seizure disorder secondary to stroke

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dave M. Fale

29c. License number: D34198

29d. Date signed (Month, Day, Year): 8/11/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Dr. DAVID FEDERLE 24035 THREE NOTCH RD. HOLLYWOOD, MD 20636

State Registrar

31. Date filed (Month, Day, Year): AUG 13 1999

32. Registrar's Signature: Linda G. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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99-4518-047
JAD

Richard T. Allewalt

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25533

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RICHARD THOMAS ALLEWALT
2. Date of Death (Month, Day, Year): August 1, 1999
3. Time of Death: 6:30AM
4a. Facility Name (If not institution, give street and number): 306 7th. Street
4b. City, Town, or Location of Death: Ocean City
4c. County of Death: Worcester County

Funeral Director

5. Social Security Number: 219-26-1799
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 60 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 7-24-39
9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD.
10b. County: WORCESTER
10c. City, Town or Location: OCEAN CITY
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 306 7TH STREET
10f. Zip Code: 21842
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MECHANIC
16b. Kind of Business/Industry: AUTOMOBILE

17. Father's Name (First, Middle, Last): WILLIAM A. ALLEWALT
18. Mother's Name (First, Middle, Maiden Surname): NELLIE ADREON

19a. Informant's Name/Relationship (Type, Print): LISA ANN ALLEN DGTR.
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1304 CONQUISTADOR DR, WESTMINSTER, MD, 21157

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): SALISBURY CREMATORY
Data: 8-4-99
20c. Location - City or Town, State: SALISBURY, MD.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: ULLRICH FUNERAL HOME BERLIN, MD. 21811

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. INTRACRANIAL GUNSHOT WOUND
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home [X] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [ ] Natural 2 [X] Accident 3 [X] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year): 8-1-99
28b. Time of Injury: 6:30 A M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: GUNSHOT SHOT SELF.
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): RESIDENCE
28f. Location (Street and Number or Rural Route Number, City or Town, State): 306 7TH ST WORCESTER CO, MD

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): August 2, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): [illegible] 111 Penn Street, Baltimore, Maryland 21201

5+1

State Registrar

31. Date filed (Month, Day, Year): AUG 04 1999
32. Registrar's Signature: [signature] D. Sparks

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ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25534

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John S. Allen

2. Date of Death (Month, Day, Year): JULY 23 1999

3. Time of Death: 12:20 PM

4a Facility Name (If not institution, give street and number): Sacred Heart Hospital

4b. City, Town, or Location of Death: Cumberland

4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 212-24-1518

6. Sex: 1☐M 2☐F — X

7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jul 20, 1920

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: Allegany

10c. City, Town or Location: Cumberland

10d. Inside City Limits: 1☐Yes 2☐No — X

10e. Street and Number: 11808 Bayberry Ave SW Potomac Pk

10f. Zip Code: 21502

10g. Citizen of What Country? USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No — If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☐No — X — Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): retired

16b. Kind of Business/Industry: tire co.

17. Father's Neme (First, Middle, Last): Lawrence Allen

18. Mother's Name (First, Middle, Maiden Surname): Irma (McCormick)

19a. Informant's Neme/Reletionship (Type, Print): Mary K. Allen wife

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11808 Bayberry Avenu;Cumberland MD 21502

20a. Method of Disposition: 1☒Buriel 2☐Cremetion 3☐Removal from State 4☐Donation 5☐Other (Specify) — X

20b. Place of Disposition (Name of cemetery, crematory or other place): Sunset Memorial Park

Date: 7/26/

20c. Location - City or Town, State: Cumberland, MD

21. Signeture of Funeral Service Licensee: Nicholas J. Scarpelli

22. Name and Address of Facility: Scarpelli Funeral Home P.A. Cumberland, Maryland 21502

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

4

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediete Cause (Finel disease or condition resulting in death)

a. Malignant Mesothelioma — 2 Weeks

Due to (or es a consequence of):

Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Asbestosis

COPD

Chronic Respiratory Failure

23b. Did tobacco use contributs to the cauus of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Wes case referred to medical examiner? 1☐Yes 2☒No

26. Place of Deeth (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA — Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician**: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and manner es stated. 2☐**Medical Examiner**: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date and piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: R Schmitt MD

29c. License number: D26333

29d. Date signed (Month, Day, Year): JULY 26 1999

30. Name and address of person who completed cause of death (Item 23a) (Type/Print): R. Schmitt 900 seton Dr. Cumberland Md 21502

State Registrar

31. Dete filed (Month, Day, Year): JUL 26 1999

32. Registrar's Signetu

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ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25535

Ethel Byrd SS# 225-32-9909 Baltimore, Maryland 21215-0020

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Ethel Byrd
2. Data of Death — Month: July Day: 28, Year: 1999
3. Time of Death: 0800
4a. Facility Name *(If not institution, give street and number)*: PENINSULA REGIONAL MEDICAL CENTER
4b. City, Town, or Location of Death: SALISBURY
4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 225-32-9909
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 72 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: 12-2-26
9. Birthplace *(State or Foreign Country)*: VA.

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: Wicomico
10c. City, Town or Location: Salisbury
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 105 Time Square
10f. Zip Code: 21801
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6th grade — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Domestic Worker
16b. Kind of Business/Industry: Farming

17. Father's Name *(First, Middle, Last)*: Abe Byrd
18. Mother's Name *(First, Middle, Maiden Surname)*: Ella Collins

19a. Informant's Name/Relationship *(Type, Print)*: Virginia Downing (Sister)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 423 South 16oth St. Phila. Pa. 19143

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mt. Sinai Cemetary
Date: 8-7-99
20c. Location - City or Town, State: Pocomoke Md. 21851

21. Signature of Funeral Service Licensee: John G. Prince
22. Name and Address of Facility: Bennie Smith Funeral Home P.O. Box 331 Pocomoke Md. 21851

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. RESPIRATORY FAILURE — 5 DAYS

Due to (or as a consequence of):
b. ASPIRATION — 5 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last
c. MULTIPLE CVA's

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: DIABETES

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Robert Allen, M.D.
29c. License number: D29168
29d. Date signed *(Month, Day, Year)*: 7/28/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Robert Allen 360 Riverside Drive A204, Salisbury Md 21801

State Registrar

31. Date filed *(Month, Day, Year)*: JUL 30 1999
32. Registrar's Signature: Donna G. Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25536

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ESPY T. BARLEY
2. Date of Death (Month, Day, Year): JULY 17, 1999
3. Time of Death: 06:05 A.M.
4a. Facility Name (If not institution, give street and number): SACRED HEART HOSPITAL
4b. City, Town, or Location of Death: CUMBERLAND
4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 214-05-5221
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 91 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): DEC. 4, 1907
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: ALLEGANY
10c. City, Town or Location: CUMBERLAND
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 105 KARNS AVENUE
10f. Zip Code: 21502
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SUPERVISOR
16b. Kind of Business/Industry: PEPSI-COLA

17. Father's Name (First, Middle, Last): WILLIAM F. BARLEY
18. Mother's Name (First, Middle, Maiden Surname): AGNES LEHMAN

19a. Informant's Name/Relationship (Type, Print): RICHARD BARLEY/BROTHER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 25022 ELCONTIJO LANE, MISSION VIEJO, CA 92675

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): SS. PETER & PAUL CEMETERY
Date: 7/22/99
20c. Location - City or Town, State: CUMBERLAND, MD

21. Signature of Funeral Service Licensee: ▶ Wendy D. Upchurch
22. Name and Address of Facility: UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD 21502

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. INTESTINAL OBSTRUCTION — DAYS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature], MD
29c. License number: D50931
29d. Data signed (Month, Day, Year): JULY 19, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): VIRGINIA G. MAGBOJOS, MD 912 SOUTH DRIVE CUMBERLAND, MD 21502

State Registrar

31. Data filed (Month, Day, Year): JUL 21 1999
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

mv 10 (1v4)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25537

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: MARY EDITH BENDER

2. Date of Death (Month, Day, Year): JULY 23 1999

3. Time of Death: 7:05 P.M.

4a Facility Neme *(If not institution, give street and number)*: ST. VINCENT de PAUL NURSING CENTER

4b. City, Town, or Location of Death: FROSTBURG

4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 212 38 7340

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 88 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: MAY 15 1911

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ALLEGANY

10c. City, Town or Location: FROSTBURG

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 5 STANDISH STREET

10f. Zip Code: 21532

10g. Citizen of What Country?: U.S.

11. Merital Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 6 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: TEACHER

16b. Kind of Business/Industry: PUBLIC SCHOOLS

17. Father's Neme *(First, Middle, Last)*: BERNARD D. DILLEY

18. Mother's Name *(First, Middle, Maiden Surname)*: AGNES KIRBY

19e. Informant's Name/Reletionship *(Type, Print)*: RALPH P. BENDER, JR.

19b. Meiting Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 5 STANDISH ST., FROSTBURG, MD 21532

20e. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other piece)*: ST. MICHAEL'S CEMETERY

Date: 7/26/99

20c. Location - City or Town, Stete: FROSTBURG, MD 21532

21. Signature of Funeral Service Licensee: Eric W. Sowers

22. Neme end Address of Facility: SOWERS FUNERAL HOME, P.A. 60 W. MAIN ST., FROSTBURG, MD 21532

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert feilure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Finel disease or condition resulting in death): e. Arteriosclerosis — 20 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in deeth) Last

b. Due to (or es a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Osteoarthritis; Chronic otitis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Deeth *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Nenturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2☐ **Medical Examiner**: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner steted.

29b. Signeture end title of certifier: [signature] MD

29c. License number: D12532

29d. Date signed *(Month, Day, Year)*: 7-27-99

12

30. Neme end address of person who completed cause of death (Item 23a) (Type, Print): George Breza, M.D. 912 Seton Dr. Cumberland, MD 21502

State Registrar

31. Dete filed *(Month, Day, Year)*: JUL 27 1999

32. Registrar's Signeture: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25538

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Hobert Franklin Bennett
2. Date of Death (Month, Day, Year): JULY 26, 1999
3. Time of Death: 11:13 P.M.
4a. Facility Name (If not institution, give street and number): Sacred Heart Hospital
4b. City, Town, or Location of Death: Cumberland
4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 214-18-6408
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 09-Mar-20
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. Stete: Maryland
10b. County: Allegany
10c. City, Town or Location: Mount Savage
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 14004 Mount Savage Road, N.W.
10f. Zip Code: 21545-
10g. Citizen of What Country?: U.S.A.

11. Meritat Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mechanic
16b. Kind of Business/Industry: state government

17. Father's Name (First, Middle, Last): Frank Pierce Bennett
18. Mother's Name (First, Middle, Meiden Surname): Dora Ellen Orndorff

19a. Informant's Neme/Reletionship (Type, Print): Debbie Rizer Niece
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 132 Hackberry Drive Stephens City Virginia 22655-

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removel from State 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Rest Lawn Memorial Gardens
Date: 30-Jul-99
20c. Location - City or Town, Stete: LaVale, Maryland

21. Signature of Funerel Service Licensee: Franklin H. Custer
22. Name and Address of Facility: Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on eech line.

Approximate Interval Between Onset and Deeth

Immediate Cause (Finel disease or condition resulting in death)
a. Septicemia — 5 days
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last
b.
Due to (or es a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.
Chronic Renal Failure - needing Hemodialysis
Chronic anyelogenous leukemia
Hypertension - COPD. Anemia

23b. Did tobacco uas contribute to the causa of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Wes an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of deeth? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature end title of certifier: SL Sandhir MD
29c. License number: D144464
29d. Dete signed (Month, Day, Year): JULY 27, ,1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Sikander Sandhir M.D. 48 Tarn Terrace Frostburg MD 21532

State Registrar

31. Date filed (Month, Day, Year): JUL 29 1999
32. Registrar's Signature: Virginia G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25539

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Loretta Christine Brittingham

2. Date of Death: Month August Day 1 Year 1999

3. Time of Death: 2:20 AM

4e Facility Name (If not institution, give street and number): Genesis ElderCare - The Pines

4b. City, Town, or Location of Death: Easton

4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 212-56-1598

6. Sex: 1☐ M 2☑ F

7. Age (In yrs. last birthday): 53 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 27, 1945

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Talbot

10c. City, Town or Location: Easton

10d. Inside City Limits: 1☑ Yes 2☐ No

10e. Street and Number: 200 South Street

10f. Zip Code: 21601

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☑ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Bus Driver

16b. Kind of Business/Industry: Upper Shore Aging Inc.

17. Father's Name (First, Middle, Last): William Potter

18. Mother's Name (First, Middle, Maiden Surname): Thelma Bailey

19e. Informant's Name/Relationship (Type, Print): Shawn Brittingham

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 204 Gardens Court Federalsburg, MD. 21632

20e. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Hammondtown Cemetery

Date: 8/05/99

20c. Location - City or Town, State: Easton, Maryland

21. Signature of Funeral Service Licensee: ▶ Janelle C. Henry

22. Name and Address of Facility: Henry Funeral Home P.A. 510 Washington St, Cambridge, MD. 21613

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Atherosclerotic Cardiovascular disease — 4 years.

Due to (or as a consequence of):

b. Dilated Cardiomyopathy — 4 years.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. End stage renal disease — 5 years.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]

29c. License number: D45148

29d. Date signed (Month, Day, Year): August, 2, 1999

32. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ricardo Osorno 606 Dutchman's Lane Easton, MD 21601

State Registrar

31. Date filed (Month, Day, Year): AUG 03 1999

32. Registrar's Signature: ▶ [signature] G. Sparks

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25540

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Walter Thomas Colona

2. Date of Death (Month, Day, Year): July 24, 1999

3. Time of Death: 1:55 PM

4a. Facility Name (If not institution, give street and number): Salisbury Center: Genesis ElderCare

4b. City, Town, or Location of Death: Salisbury, MD

4c. County of Death: Wicomico

Funeral Director

5. Social Security Number: 214-12-6475

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 03 17 1921

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: MD

10b. County: Wicomico

10c. City, Town or Location: 5712 Argyle Dr., Parsonsburg

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 5712 Argyle Dr.

10f. Zip Code: 21849

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerk

16b. Kind of Business/Industry: Retail Grocery

17. Father's Name (First, Middle, Last): Shelton Thomas Colona

18. Mother's Name (First, Middle, Maiden Surname): Emma Katherine Gibbons

19a. Informant's Name/Reletionship (Type, Print): Anna Budd Colona- Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5712 Argyle Dr., Parsonsburg, Md. 21849

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Parksley Cemetery | Date: 07/27/99

20c. Location - City or Town, State: Parksley, Virginia

21. Signature of Funeral Service Licensee: John I. Williams

22. Name and Address of Facility: Williams-Parksley Funeral Home, 25046 Parksley Rd., Parksley, Virginia 23421

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Pneumonia — One Day

Due to (or as a consequence of):
b. MCD Dementia and History of Stroke

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M Atkins

29c. License number: D-B9813

29d. Date signed (Month, Day, Year): 7/26/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): M Atkins 1101 Healthway Drive Salisbury MD 21804

State Registrar

31. Date filed (Month, Day, Year): AUG 03 1999

32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

99-4452-015
crn
Jerry Dean Crouse, Sr.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25541

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jerry Dean Crouse, Sr.

2. Date of Death (Month, Day, Year): July 28, 1999

3. Time of Death: 10:02 A.M.

4a. Facility Name (If not institution, give street and number): Old Field Point Road near Landing Lane

4b. City, Town, or Location of Death: Elkton

4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 220-52-3347

6. Sex: 1☒M 2☐F

7. Age (In yrs. last birthday): 49 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 7, 1949

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Conowingo

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 184 Rowlandsville Road

10f. Zip Code: 21918

10g. Citizen of What Country? USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Heavy Equipment Operator

16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): Charlie Letcher Crouse, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Aline (nmn) Dancy

19a. Informant's Name/Relationship (Type, Print): Carlotta E. Crouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 184 Rowlandsville Road, Conowingo, MD 21918

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Bel Air Memorial Gardens

Date: 7-31-99

20c. Location - City or Town, State: Bel Air, Maryland

21. Signature of Funeral Service Licensee: Holly K. McComas

22. Name and Address of Facility: McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Head and Neck Injuries

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☒Yes 2☐No

24b. Were autopsy findings available prior to completion of cause of death? 1☒Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) at scene

27. Manner of Death: 1☐Natural 2☒Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year): 7/28/99

28b. Time of Injury: 0940HRS

28c. Injury at Work? 1☒Yes 2☐No

28d. Describe how injury occurred: Struck by pole Subject

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Worksite

28f. Location (Street and Number or Rural Route Number, City or Town, State): Old Field Point Road Perryville Maryland

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Theodore M. Kinning

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): July 29, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THEODORE MINING 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JUL 30 1999

32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25542

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ORVILLE EDWARD CROWE
2. Date of Death (Month, Day, Year): JULY 16 1999
3. Time of Death: 1:05 P.M.
4a. Facility Name (If not institution, give street and number): ST. VINCENT de PAUL NURSING CENTER
4b. City, Town, or Location of Death: FROSTBURG
4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 217 10 5249
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): APRIL 21 1918
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ALLEGANY
10c. City, Town or Location: FROSTBURG
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 205 MAPLE PLACE
10f. Zip Code: 21532
10g. Citizen of What Country?: U.S.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): TWISTING DEPARTMENT
16b. Kind of Business/Industry: CELANESE

17. Father's Name (First, Middle, Last): WILLIAM CROWE
18. Mother's Name (First, Middle, Maiden Surname): MARY MORGAN

19a. Informant's Name/Relationship (Type, Print): ADA M. CROWE / WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 205 MAPLE PLACE, FROSTBURG, MD 21532

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): CUMBERLAND CREMATORY | Date: 7/17/99
20c. Location - City or Town, State: CUMBERLAND, MD

21. Signature of Funeral Service Licensee: Eric D. Sowers
22. Name and Address of Facility: SOWERS FUNERAL HOME, P.A. 60 W. MAIN ST., FROSTBURG, MD 21532

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Sepsis	3 hours
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: cold agglutinin disease; Cerebello - Olivo - pontine degenerative disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D21244
29d. Date signed (Month, Day, Year): 7/16/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JESUS H. TAN, M.D., FROSTBURG PLAZA, FROSTBURG, MD 21532

State Registrar

31. Date filed (Month, Day, Year): JUL 20 1999
32. Registrar's Signature: Geneva G. Frantz

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

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Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25543

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Raymond Junior Castle
2. Dete of Deeth: Month 7 Dey 25 Yeer 99
3. Time of Death: 1630 EDT
4e. Feciiity Neme (If not institution, give street end number): Egle Nursing Home
4b. City, Town, or Location of Deeth: Lonaconing
4c. County of Deeth: Allegany

Funeral Director

5. Social Security Number: 216-18-1950
6. Sex: 1 X M 2 ☐ F
7. Age (In yrs. last birthday): 76 Yrs.
If Under 1 Yeer: Months / Deys
If Under 24 Hrs.: Hours / Min.
8. Dale of Birth (Month, Day, Year): April 8, 1923
9. Birthpiace (Stete or Foreign Country): MD

Usuei Residenca of Decedeni

10e. Stete: MD
10b. County: Allegany
10c. City, Town or Location: Lonaconing
10d. Inside City Limits: 1 X Yes 2 ☐ No
10e. Street end Number: 14 W. Railroad Street
10f. Zip Code: 21539
10g. Citizen of Whet Counlry?: USA
11. Maritei Siaius: 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorcad
12. Wes Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Yeer or Dales: Navy WWII
13. Wes Decedeni of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 X No Specify:
14. Rece - American Indien, Bleck, White, etc. Specify: White
15. Decedent's Education (Specify only highest grede completed): Elementary/Secondary (0-12): 12 College (1-4or 5+): 0
16e. Decedeni's Usuei Occupetion (Give kind of work done during most of working life. DO NOT use retired): Labor
16b. Kind of Business/Industry: Sanitation
17. Fether's Neme (First, Middle, Last): Clarence Castle
18. Mother's Neme (First, Middle, Maiden Sumeme): Marion Scott
19e. Informent's Name/Relationship (Type, Print): Deane Fitzgerald Niece
19b. Maiiing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 14304 Greenfield Cres, Cumberland, MD 21502
20e. Method of Disposition: 1 ☐ Burial 2 X Cremetion 3 ☐ Removei from State 4 ☐ Donetion 5 ☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Cumberland Crematory
Date: July 26 1999
20c. Location - City or Town, Stete: Cumberland, MD
21. Signature of Funerai Servica Licensee: ▶ James E McKenzie
22. Name end Address of Feciiity: Eichhorn-McKenzie Funeral Home P.A. Lonaconing, MD 21539

Physician /Medicai Examiner

23e. Pert I. Enter the diseese, or complicetions thet caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert feilure. List only one ceuse on each line.

Approximete Intervei Between Onset end Deeth

Immediete Ceuse (Finel disease or condition resulting in deeth): e. Acute respiratory Failure — 10 min.

Due to (or es e consequenca of):

Sequentially list conditions, if eny, ieeding to immediate cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest:
b. Chronic respiratory Failure — 10 years
Due to (or es e consequence of):
c. Chronic obstructive pulmonary disease — 20 years.
Due to (or es e consequence of):
d.

Pert Ii. **Other significant conditions** contributing to death bui not resulting in the underlying cause given in Pert I.: Congestive Heart Failure; Dementia of the Alzheimer Type.; Non insulin dependent Diabetes mellitus

23b. Did tobacco use contribute to the cause of death? 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24e. Wes en eutopsy performed? 1 ☐ Yes 2 X No

24b. Were eutopsy findings eveileble prior to compietion of cause of deeth? 1 ☐ Yes 2 ☐ No

25. Wes case referred to medicai exeminer? 1 ☐ Yes 2 X No

26. Piace of Deeth (Check only one): Hospitel: 1 ☐ inpatient 2 ☐ ER/Outpetient 3 ☐ DOA; Other: 4 X Nursing Home 5 ☐ Residenca 8 ☐ Other (Specify)

27. Menner of Deeth: 1 X Neiurel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28e. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Piace of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Locetion (Street end Number or Rurel Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1 X **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted. 2 ☐ **Medical Examiner**: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner stated.

29b. Signature end title of certifier: ▶ Thomas J. Dellimo

29c. License number: D21498

29d. Dete signed (Month, Dey, Yeer): July 26, 1999

30. Neme and address of person who completed cause of deeth (item 23e) (Type, Print): Thomas J. Dellimo MD, 20 Douglas Ave, Lonaconing, Md 21539

State Registrar

31. Dete filed (Month, Day, Year): JUL 27 1999

32. Registrar's Signeture: ▶ Brenda B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health end Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

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Medical Certification: To Be Completed by Physician/Medical Examiner

Amended # 206
Allegany County Health Dept
7/20/99 MLV

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25544

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DOROTHY MAE DUDLEY
2. Date of Death Month / Dey / Yeer: JULY 18 1999
3. Time of Death: 11:37 A.M.
4a. Facility Name (If not institution, give street and number): SACRED HEART HOSPITAL
4b. City, Town, or Location of Death: CUMBERLAND
4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 213 10 9661
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): FEB 5 1915
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ALLEGANY
10c. City, Town or Location: FROSTBURG
10d. Inside City Limits: 1☒ Yes 2☐ No
10a. Street and Number: 117 W. MECHANIC STREET
10f. Zip Code: 21532
10g. Citizen of Whet Country?: U.S.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - American Indien, Bleck, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): EDWARD MONAHAN
16. Mother's Name (First, Middle, Maiden Surname): MARGARET MICHAEL

19a. Informant's Name/Relationship (Type, Print): SONDRA RITCHIE / DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 126 WASHINGTON ST., FROSTBURG, MD 21532

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ECKHART CEMETERY Date: 7/20/99 ~~7/20/00~~
20c. Location - City or Town, State: ECKHART, MD

21. Signature of Funeral Service Licensee: Eric D. Sowers
22. Name and Address of Facility: SOWERS FUNERAL HOME, P.A. 60 W. MAIN ST., FROSTBURG, MD 21532

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Ceuse (Finel disease or condition resulting in death) a.	CARDIAC ARREST : ASYSTOL	ONE HOUR
Due to (or as a consequence of): b.	DIABETES MELLITES	19 YEARS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	HYPERTENSION	20 YEARS
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uss contribuls to the causs of death? 1☐ Yss 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings eveilable prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☒ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury st Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) snd manner ss stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred st the time, date snd plsce, and due to the csuse(s) and manner stated.

29b. Signature and title of certifier: Charles Lynn Kinsey M.D.
29c. License number: D24951
29d. Dete signed (Month, Dey, Year): JULY 19, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RONALD C. KINSEY, M.D., 900 SETON DRIVE, CUMBERLAND, MD 21502

State Registrar

31. Date filed (Month, Day, Year): JUL 20 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rsv 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

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Medical Certification: To Be Completed by Physician/Medical Examiner

MV 15

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25545

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARTHA JANE EVERLY

2. Date of Death: Month July Day 30 Year 1999

3. Time of Death: 10:40 pm

4a. Facility Name (If not institution, give street and number): Sacred Heart Hospital

4b. City, Town, or Location of Death: Cumberland

4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 220-26-7653

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 67 Yrs.

If Under 1 Year: Months ___ Days ___ If Under 24 Hrs.: Hours ___ Min. ___

8. Date of Birth (Month, Day, Year): Oct. 25, 1931

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: WV

10b. County: Mineral

10c. City, Town or Location: Keyser

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1350 Terri Street

10f. Zip Code: 26726

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) 11; College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Lester W. Dayton

18. Mother's Name (First, Middle, Maiden Surname): Alma Leona Clark

19a. Informant's Name/Relationship (Type, Print): Leona M. Morgan/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 19404 Toms Hollow Rd., S.W. Rawlings, MD 21557

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Potomac Memorial Gardens

Date: Aug. 3 1999

20c. Location - City or Town, State: Keyser, WV

21. Signature of Funeral Service Licensee: Brian L. Smith

22. Name and Address of Facility: Smith Funeral Home 85 S. Main Street Keyser, WV 26726

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Brain Metastasis	6 months
Due to (or as a consequence of): b.	Cancer of lung	1 year
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): c.	Paralysis of left side	2 week
d.	Recurrent seizure	1 week

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John Mehanna M.D

29c. License number: D-17526

29d. Date signed (Month, Day, Year): August, 2, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John Mehanna M.D. 902 Seton Drive Cumberland MD 21502

State Registrar

31. Date filed (Month, Day, Year): AUG 04 1999

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

99 25546
Reg. No.

Amended item #16b, 7/30/99, WCHD, E.T

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HILDA M. FARK
2. Date of Death Month / Day / Year: JULY 28, 1999
3. Time of Death: 0400
4a. Facility Name (If not institution, give street and number): 176 WINDJAMMER RD.
4b. City, Town, or Location of Death: OCEAN PINES
4c. County of Death: WORCESTER

Funeral Director

5. Social Security Number: 578-30-3299
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 73 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 9-14-25
9. Birthplace (State or Foreign Country): WASH., DC

Usual Residence of Decedent

10a. State: MD.
10b. County: WORCESTER
10c. City, Town or Location: OCEAN PINES
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 176 WINDJAMMER RD.
10f. Zip Code: 21811
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SUPERVISOR
16b. Kind of Business/Industry: US Government ~~UD GAVERNMENT~~

17. Father's Name (First, Middle, Last): OSCAR E. MOLLARI
18. Mother's Name (First, Middle, Maiden Surname): FRANCES SLAVIK

19a. Interment's Name/Relationship (Type, Print): DAVID BRUCE ALLEN SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): ARNOLD, MARYLAND

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): SALISBURY CREMATORY
Date: 7-30
20c. Location - City or Town, State: SALISBURY, MD.

21. Signature of Funeral Service Licensee: John A Ullrich
22. Name and Address of Facility: ULLRICH FUNERAL HOME BERLIN, MD., 21811

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Myocardial Infarction — Minutes
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Arteriosclerotic Heart Disease — years
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Adenocarcinoma of the Lung
Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD
29c. License number: D30619
29d. Date signed (Month, Day, Year): 7/29/99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PETER S ABBOTT MD 10445 Ocean City Blvd Berlin Md 21811

State Registrar

31. Date filed (Month, Day, Year): JUL 30 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25547

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GLADYS EVELYN FLANAGAN

2. Date of Death: Month 07 Day 16 Year 1999

3. Time of Death: 4:45 p.m.

4a. Facility Name (If not institution, give street and number): Memorial Hospital

4b. City, Town, or Location of Death: Cumberland

4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 215-20-6393

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan 27, 1925

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: WV

10b. County: Mineral

10c. City, Town or Location: Ft. Ashby

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: Painter Hollow Road

10f. Zip Code: 26719

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Home maker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Charles Valentine

18. Mother's Name (First, Middle, Maiden Surname): Virginia Bridges

19a. Informant's Name/Relationship (Type, Print): Stewart O. Flanagan,Sr./Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): HC 86 Box 16 Ft. Ashby, WV 26719

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Ft. Ashby Cemetery | Date: 7/19/99

20c. Location - City or Town, State: Ft. Ashby, WV

21. Signature of Funeral Service Licensee: Wendy A. Upchurch

22. Name and Address of Facility: Upchurch Funeral Home, Inc. P.O.Box 1260 Ft. Ashby, WV 26719

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. SEPTIC SHOCK — 3 DAYS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: William Lamm MD

29c. License number: D25406

29d. Date signed (Month, Day, Year): July 19, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. William Lamm, 47 Virginia Avenue, Cumberland, Maryland 21502

State Registrar

31. Date filed (Month, Day, Year): JUL 22 1999

32. Registrar's Signature: Geneva B. Sparks

Gladys Flanagan 215-20-6393

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25548

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Rose Mary Fabbri
2. Date of Death Month Day Year: JULY 28, 1999
3. Time of Death: 0345 AM
4a. Facility Name (If not institution, give street and number): Sacred Heart Hospital
4b. City, Town, or Location of Death: Cumberland
4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 213-24-5120
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 87 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 25-Jun-12
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Allegany
10c. City, Town or Location: Frostburg
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: Valley View Apartments #210 81E. Mechanic Street
10f. Zip Code: 21532-
10g. Citizen of What Country? U.S.A.
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Seamstress
16b. Kind of Business/Industry: Clothing manufacturing
17. Father's Name (First, Middle, Last): Samuel Rogano
18. Mother's Name (First, Middle, Maiden Surname): Frances Bisigano
19a. Informant's Name/Relationship (Type, Print): Benilda Robertson Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 17215 Porter Road, S.W. Eckhart Mines Maryland 21532-
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Saint Michaels Cemetery
Date: 31-Jul-99
20c. Location - City or Town, State: Frostburg, Maryland
21. Signature of Funeral Service Licensee: Franklin H. Custer
22. Name and Address of Facility: Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pulmonary Edema - CHF — 12 hours
Due to (or as a consequence of):
b. ASHD
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
c. Total Dementia — 5 years
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John McNamara M.D.
29c. License number: D-17526
29d. Date signed (Month, Day, Year): JULY, 28, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John McNamara M.D. 902 Seton Drive Cumberland, MD 21502

State Registrar

31. Date filed (Month, Day, Year): JUL 29 1999
32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25549

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Herman Geier

2. Date of Death (Month, Day, Year): August 3, 1999

3. Time of Death: 8:45 PM

4a. Facility Name *(If not institution, give street and number)*: The Hebrew Home of Greater Washington

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 067-09-2592

6. Sex: 1☐M 2☐F XX

7. Age *(In yrs. last birthday)*: 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Feb. 4, 1918

9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Bethesda

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 5225 Pooks Hill Rd.

10f. Zip Code:

10g. Citizen of What Country?: United States

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): | College (1-4or 5+): 5 +

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Marketing/Liquor

16b. Kind of Business/Industry: Private

17. Father's Name *(First, Middle, Last)*: Morris Paul Geier

18. Mother's Name *(First, Middle, Maiden Surname)*: Rebecca Shenkman

19a. Informant's Name/Relationship *(Type, Print)*: Eileen G. Sapcariu

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 12909 Morring Side La. Silver Spring, MD.

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mt. Lebanon | Date: 8/6

20c. Location - City or Town, State: Adeliphi, MD.

21. Signature of Funeral Service Licensee: Michael Boyle

22. Name and Address of Facility: Stein Hebrew Memorial FH 232 Carroll St. NW, Washington, DC, 20012

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: DELIRIUM

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☒Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Gregory A Compton MD

29c. License number: D24942

29d. Date signed *(Month, Day, Year)*: AUG 04 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): GREGORY A. COMPTON MD 6121 Montrose Rd Rockville MD

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 13 1999

32. Registrar's Signature: [illegible] B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25550

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ESTHER LUCILLE HENRY

2. Date of Death Month Day Year: AUGUST 3 1999

3. Time of Death: 8:00 AM

4a. Facility Name *(If not institution, give street and number)*: 6509 Elk Court

4b. City, Town, or Location of Death: Waldorf

4c. County of Death: Charles

Funeral Director

5. Social Security Number: 577-36-9653

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 82 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: April 14 1917

9. Birthplace *(State or Foreign Country)*: Ohio

Usual Residence of Decedent

10a. State: Maryland

10b. County: Charles

10c. City, Town or Location: Waldorf

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 6509 Elk Court

10f. Zip Code: 20603

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Clerk

16b. Kind of Business/Industry: US Government

17. Father's Name *(First, Middle, Last)*: Ben Fowler

18. Mother's Name *(First, Middle, Maiden Surname)*: Ada McKee Fowler

19a. Informant's Name/Relationship *(Type, Print)*: Georgia A. Henry (PRD)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 411 Garner Ave Waldorf, MD 20602

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metropolitan Crematory

Date: 8-4-99

20c. Location - City or Town, State: Alexandria, VA

21. Signature of Funeral Service Licensee: John A. Eberwein M00173

22. Name and Address of Facility: J.H. Eberwein Mortuary, 4433 White Pls La White Pls., MD 20695

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Cardiac Arrest

Due to (or as a consequence of):

b. CAD, Cardiac Amputations

Due to (or as a consequence of):

c. CVA Stroke, Seizure

Due to (or as a consequence of):

d. HTN, TIAS, PUD

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* Assisted Living

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Abulhasan Ansari MD

29c. License number: D0024208

29d. Date signed *(Month, Day, Year)*: 8.3.1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Abulhasan Ansari MD 8926 Woodyard Road #101 Clinton, MD 20735

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 04 1999

32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25551

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CARL FRANKLIN HAGER
2. Date of Death: Month JULY Day 15 Year 1999
3. Time of Death: 1:40 p.m
4a. Facility Name (If not institution, give street and number): SACRED HEART HOSPITAL
4b. City, Town, or Location of Death: CUMBERLAND
4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 220 26 7513
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 70 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JUNE 13 1929
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ALLEGANY
10c. City, Town or Location: FROSTBURG
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 10516 TENNANTS LANE, NW
10f. Zip Code: 21532
10g. Citizen of What Country?: U.S.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 5/17/51 5/16/57
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MASTER TECHNICIAN
16b. Kind of Business/Industry: BALLISTICS

17. Father's Name (First, Middle, Last): FRANK J. HAGER
18. Mother's Name (First, Middle, Maiden Surname): EDNA LASHBAUGH

19a. Informant's Name/Relationship (Type, Print): JACQUELINE HAGER / WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10516 TENNANTS LANE, NW, FROSTBURG, MD 21532

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): REST LAWN MEMORIAL GARDENS Date: 7/17/99
20c. Location - City or Town, State: LaVALE, MD

21. Signature of Funeral Service Licensee: Alan M Sowers
22. Name and Address of Facility: SOWERS FUNERAL HOME, P.A. 60 W. MAIN ST., FROSTBURG, MD 21532

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	CARCINOMA OF LUNG	1 YEAR
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.		
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: END STAGE RENAL DISEASE S/P TRANSPLANTATION; CONGESTIVE HEART FAILURE

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Robert Welik M.D. Medical Doctor
29c. License number: D31870
29d. Date signed (Month, Day, Year): JULY 15 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ROBERT WELIK, M.D., 902 SETON DRIVE, CUMBERLAND, MD 21502

State Registrar

31. Date filed (Month, Day, Year): JUL 20 1999
32. Registrar's Signature: Geneva G. Sowers

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

MU9 (IVA)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25552

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Justus Allan Hovey, Jr.

2. Date of Death (Month, Day, Year): July 21, 1999

3. Time of Death: 1539

4a. Facility Name (If not institution, give street and number): Sacred Heart Hospital

4b. City, Town, or Location of Death: Cumberland

4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 126-01-2633

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 77 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 13, 1922

9. Birthplace (State or Foreign Country): MA

Usual Residence of Decedent

10a. State: WV

10b. County: Hampshire

10c. City, Town or Location: Green Spring

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: PO Box 144

10f. Zip Code: 26722

10g. Citizen of What Country: US

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1943-47

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): International Relations Rep.

16b. Kind of Business/Industry: Gen. Accounting Office US Gov.

17. Father's Name (First, Middle, Last): Justus Allan Hovey, Jr.

18. Mother's Name (First, Middle, Maiden Surname): Lois E. Clark

19a. Informant's Name/Relationship (Type, Print): Anne E. Brandolini Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6221 Stonehunt Place, Clifton, VA 20124

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Omps Cremation Service

Date: July 22, 1999

20c. Location - City or Town, State: Winchester, VA

21. Signature of Funeral Service Licensee: Sarah Morgan

22. Name and Address of Facility: Shaffer Funeral Home, Inc. 230 E. Main ST., Romney, WV 26757

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. MYOCARDIAL INFARCTION — 7 hours

Due to (or as a consequence of):
b. HYPERTENSIVE CARDIOVASCULAR DISEASE — 15 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one)
Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA
Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Name Illegible MD ME

29c. License number: D09731

29d. Data signed (Month, Day, Year): July 21, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DONALD E MANGER 14427 HAZEN ROAD CUMBERLAND MD 21502

State Registrar

31. Date filed (Month, Day, Year): JUL 26 1999

32. Registrar's Signature: Virginia D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10 years

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25553

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Eddie Cecil Humbertson
2. Date of Death Month Day Year: Jul 27, 1999
3. Time of Death: 03:10pm
4a. Facility Name *(If not institution, give street and number)*: Memorial Hospital
4b. City, Town, or Location of Death: Cumberland
4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 213-44-1961
6. Sex: 1 ☐ M 2 ☐ F — X
7. Age *(In yrs. last birthday)*: 52 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Oct 19, 1946
9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD
10b. County: Allegany
10c. City, Town or Location: Cumberland
10d. Inside City Limits: 1 ☐ Yes 2 ☐ No — X
10e. Street and Number: 14201 Baltimore Pike
10f. Zip Code: 21502
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married — X 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No — X — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☐ No — X — Specify:
14. Race - American Indian, Black, White, etc. — Specify: white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Baker
16b. Kind of Business/Industry: Restaurant

17. Father's Name *(First, Middle, Last)*: Thomas C. Humbertson
18. Mother's Name *(First, Middle, Maiden Surname)*: Edith A (Humbertson)

19a. Informant's Name/Relationship *(Type, Print)*: Linda L. Humbertson wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 14201 Baltimore Pike;Cumberland, MD 21502

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Cumberland Crematory
Date: 7/30/
20c. Location - City or Town, State: Cumberland, MD

21. Signature of Funeral Service Licensee: Nicholas J. Scarpelli
22. Name and Address of Facility: Scarpelli Funeral Home P.A. Cumberland, Maryland 21502

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Acute Myocardial Infarction — 2 hours

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury: M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D09157
29d. Date signed *(Month, Day, Year)*: Jul 27, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Paul Snow M.D. 124 W. 3rd Street Cumberland MD 21502

State Registrar

31. Date filed *(Month, Day, Year)*: JUL 28 1999
32. Registrar's Signature: Brenda G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25554

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Edward M. Hadley
2. Date of Death Month Day Year: JULY 27, 1999
3. Time of Death: 11:19 AM
4a. Facility Name (If not institution, give street and number): MEMORIAL HOSPITAL
4b. City, Town, or Location of Death: CUMBERLAND
4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 216-18-1350
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan 28, 1925
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Allegany
10c. City, Town or Location: Cumberland
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 14005 Uhl Highway
10f. Zip Code: 21502
10g. Citizen of What Country: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? [X] Yes 2 [ ] No If Yes, Give Yaar or Dates: WW II & Korea
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - Amarican Indian, Bleck, White, etc. Specify: white
15. Decedent's Education (Specify only highast greda compiated): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Retired Food Dept.
16b. Kind of Businass/Industry: Hospital
17. Father's Name (First, Middle, Last): George Edward Hadley
18. Mother's Name (First, Middle, Maiden Surneme): Mary (Holmes)
19a. Informent's Name/Relationship (Type, Print): Carl B. Hadley brother
19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code): 14005 Uhl Highway;Cumberland MD 21502
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Removal from Stata 4 [ ] Donation 5 [ ] Other (Specify)
20b. Piece of Disposition (Name of cemetery, crematory or other piece): Rocky Gap Veterans Cem
Date: 7/29/
20c. Location - City or Town, Steta: Flintstone, MD
21. Signature of Funaral Service Licensee: Nicholas J. Scarpelli
22. Name and Address of Facility: Scarpelli Funeral Home P.A. Cumberland, Maryland 21502

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

		Approximate Interval Between Onset and Death
Immediate Ceuse (Finel disaasa or condition resulting in death) a.	ACUTE RESPIRATORY FAILURE	4 DAYS
Dua to (or as s consequence of): b.	ACUTE BRONCHITIS	5 DAYS
Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last. Due to (or as e consequence of): c.	CHRONIC OBSTRUCTIVE LUNG DISEASE	10 YEARS
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause given in Part I.

23b. Did tobacco uss contributs to the cause of death? 1 [X] Yss 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Wara autopsy findings aveilable prior to completion of causa of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examinar? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospitel: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Mennar of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Panding Investigetion 6 [ ] Could not be detarmined

28a. Dete of Injury (Month, Day Year)
28b. Tima of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At homa, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Steta)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To tha best of my knowledge, death occurred at the tima, data and place, and dua to the causa(s) and mannar as stated. 2 [ ] **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, death occurred at tha tima, data end place, snd due to tha cause(s) and menner steted.

29b. Signature and title of certifiar: MD
29c. License number: D23334
29d. Data signed (Month, Day, Year): July 29th 1999

30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print): DINESH SHAH, M.D., JOHNSON HEIGHTS MEDICAL BUDG CUMBERLAND MD 21502

State Registrar

31. Date filed (Month, Day, Year): JUL 30 1999
32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

EDWARD HADLEY 216-18-1350

6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25555

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: BIRTSELL BRYAN HALLER

2. Date of Death Month Day Year: July 30, 1999

3. Time of Death: 0425 a.m.

4a. Facility Name *(If not institution, give street and number)*: SACRED HEART HOSPITAL

4b. City, Town, or Location of Death: CUMBERLAND

4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 219-03-6028

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 87 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: MAY 12 1912

9. Birthplace *(State or Foreign Country)*: W.VA.

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ALLEGANY

10c. City, Town or Location: CUMBERLAND

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 213 EAST MARY STREET

10f. Zip Code: 21502

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WW11

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: KELLY SPRINGFIELD TIRE CO.

16b. Kind of Business/Industry: CURNING ROOM/TIRES

17. Father's Name *(First, Middle, Last)*: GEORGE M. HALLER

18. Mother's Name *(First, Middle, Maiden Surname)*: LAURA S. TRIPLETT

19a. Informant's Name/Relationship *(Type, Print)*: GEORGE M. HALLER SON

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 223 HUMBIRD STREET CUMBERLAND MARYLAND 21502

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: SUNSET CEMETERY

Date: AUGUST 2, 1999

20c. Location - City or Town, State: CUMBERLAND MARYLAND

21. Signature of Funeral Service Licensee: Dale L. Merritt

22. Name and Address of Facility: MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	MASSIVE RIGHT CEREBRAL VASCULAR ACCIDENT	TWO WEEKS
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.	CEREBRAL VASCULAR DISEASE / ATHEROSIS	TEN YEARS
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

26a. Date of Injury *(Month, Day Year)*

26b. Time of Injury

26c. Injury at Work? 1☐ Yes 2☐ No

26d. Describe how injury occurred

26e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

26f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D33417 (MD)

29d. Date signed *(Month, Day, Year)*: July 30, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JAMES R. MOEN, MD 1068 NATIONAL HIGHWAY LAVALE, MARYLAND 21502

State Registrar

31. Date filed *(Month, Day, Year)*: JUL 30 1999

32. Registrar's Signature: Denise D. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25556

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: BOYCE JOAN INSLEY

2. Date of Death Month / Day / Year: 07 / 31 / 1999

3. Time of Death: 1155AM

4a. Facility Name *(If not institution, give street and number)*: 2230 Andrews Rd.

4b. City, Town, or Location of Death: Crapo

4c. County of Death: Dorchester

Funeral Director

5. Social Security Number: 214-28-8202

6. Sex: 1☒M 2☐F

7. Age *(In yrs. last birthday)*: 66 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: Aug 21 1932

9. Birthplace *(State or Foraign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Dorchester

10c. City, Town or Location: Crapo

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 2230 Andrews Rd.

10f. Zip Code: 21626

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐Yas 2☒No If Yes, Give Year or Dates:

13. Was Dacedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grada completad)*: Elementary/Secondary (0-12): 7; College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: heavy equipment operator

16b. Kind of Business/Industry: excavating contractor

17. Father's Name *(First, Middle, Last)*: Walter Webster Insley

18. Mother's Name *(First, Middle, Maiden Surname)*: Naomi McFeeters

19a. Informant's Name/Relationship *(Type, Print)*: Linda I. Hayward - daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: R.R. 2, Box 164, Greenwood DE 19950

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Spacify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Dorchester Memorial Park

Date: 8-3-99

20c. Location - City or Town, State: Cambridge, Maryland

21. Signature of Funeral Service Licensee: ▶ Kenneth R. Thomas Jr.

22. Nama and Address of Facility: Thomas Funeral Home PA, 700 Locust St. Cambridge, MD 21613

Physician /Medical Examiner

23a. Part1. Enter the disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ona cause on each line.

Approximate interval Between Onsat and Death

Immediate Cause (Finai disease or condition resulting in death)

a. Cardiac Arrhythmia — 4min

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part Ii. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: History of Laryngeal Cancer

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yas 2☒No

24b. Were autopsy findings available prior to completion of causa of death? 1☐Yes 2☒No

25. Was cese referred to medicei examiner? 1☒Yes 2☐No

26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☒Residanca 6☐Othar *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office buiiding, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piace, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]

29c. License number: D26388

29d. Date signed *(Month, Day, Year)*: 08-03-1999

30. Name and address of person who completed cause of death (item 23a) (Type, Print): Michael Fiddler MD 302 Collins Hurlock MD 21643

State Registrar

31. Data filed *(Month, Day, Year)*: AUG 03 1999

32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25557

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Chelsea R Johnson
2. Date of Death Month: 8 Day: 2 Year: 99
3. Time of Death: 0802
4a. Facility Name (If not institution, give street and number): Atlantic General Hospital
4b. City, Town, or Location of Death: Berlin
4c. County of Death: Worcester

Funeral Director

5. Social Security Number: 222-82-1669
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 6 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 08-23-1992
9. Birthplace (State or Foreign Country): LEWES, DELAWARE

Usual Residence of Decedent

10a. Stete: DELAWARE
10b. County: SUSSEX
10c. City, Town or Location: GEORGETOWN
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: RD#1 BOX 287
10f. Zip Code: 19947
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 1 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): NONE
16b. Kind of Business/Industry: NONE

17. Father's Name (First, Middle, Last): WILLIAM JOHNSON
18. Mother's Name (First, Middle, Maiden Surname): THERESA LECATES

19a. Informant's Name/Relationship (Type, Print): THERESA JOHNSON/MOTHER
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): RD#1 BOX 287, GEORGETOWN, DELAWARE. 19947

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): DAGSBORO REDMENS MEMORIAL CEMETERY
Dete: 08-06-99
20c. Location - City or Town, State: DAGSBORO, DELAWARE

21. Signature of Funeral Service Licensee: [signature]
22. Neme end Address of Facility: MELSON FUNERAL SERVICES, LTD. 43 THATCHER STREET, FRANKFORD, DELAWARE. 19945

Physician /Medical Examiner

23a. Part1. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Respiratory failure
Due to (or as e consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Aspiration Pneumonia
Due to (or as a consequence of):
c.
Due to (or es a consequence of):
d.

Part II. **Other significant conditione** contributing to death but not resulting in the underlying ceuse given in Part I.
Cerebral palsey, Hypothyroid, Adrenal Insufficiency
Reflux, Unidentified chromosomal disorder

23b. Did tobacco use contribute to the cauee of death? 1☐ Yee 2☒ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and dua to the cause(s) end manner stated.
29b. Signature and title of certifier: [signature] Jeffrey T. Greenwood MD
29c. License number: D48130
29d. Date signed (Month, Day, Year): 8/2/99
30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Jeffrey Thomas Greenwood MD 9733 Heathway Drive Berlin, MD

State Registrar

31. Date filed (Month, Day, Year): AUG 05 1999
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

08/02/99 @ 0802

Chelsea R. Johnson 222-82-1669

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25558

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Milagros Johnson

2. Date of Death Month: July Day: 8 Year: 1999

3. Time of Death: 11:45 a.m.

4a. Facility Name *(If not institution, give street and number)*: Cuppett-Weeks Nursing Home

4b. City, Town, or Location of Death: Oakland

4c. County of Death: Garrett

Funeral Director

5. Social Security Number: 236-48-3070

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Nov. 27, 1925

9. Birthplace *(State or Foreign Country)*: Puerto Rico

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: WV

10b. County: Mineral

10c. City, Town or Location: Keyser

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: Rt. 2, Box 83

10f. Zip Code: 26726

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☒ Yes 2☐ No *Specify:* Puerto Rican

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): | College (1-4 or 5+): 2

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Seamstress

16b. Kind of Business/Industry: Garment Manufacturing

17. Father's Name *(First, Middle, Last)*: Justo Ramos

18. Mother's Name *(First, Middle, Maiden Surname)*: Garcia (Maiden name unknown)

19a. Informant's Name/Relationship *(Type, Print)*: Madison Bryan Johnson/Husband

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: Rt. 2, Box 83 Keyser, WV 26726

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Fort Ashby Cemetery | Date: July 11 1999

20c. Location - City or Town, State: Fort Ashby, WV

21. Signature of Funeral Service Licensee: Brian L. Smith

22. Name and Address of Facility: Smith Funeral Home 85 S. Main Street Keyser, WV 26726

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Alzheimer's Disease — 2 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Date of Injury *(Month, Day Year)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: H 26154

29d. Date signed *(Month, Day, Year)*: 7/8/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Paul Daniel Miller, D.O. 69 Wolfe Acres Drive Oakland, MD 21550

State Registrar

31. Date filed *(Month, Day, Year)*: JUL 26 1999

32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

3

MD

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25559

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John F. Kleinstuber
2. Date of Death: Month 08 Day 02 Year 99
3. Time of Death: 9:37pm
4e. Facility Name (If not institution, give street and number): Atlantic General Hospital
4b. City, Town, or Location of Death: Berlin
4c. County of Death: WORCESTER

Funeral Director

5. Social Security Number: 579-30-4948
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 69 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 12-05-1929
9. Birthplace (State or Foreign Country): PENNSYLVANIA

Usual Residence of Decedent

10e. State: DELAWARE
10b. County: SUSSEX
10c. City, Town or Location: FENWICK ISLAND
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 31 DAGSBORO STREET
10f. Zip Code: 19944
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 4
16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SELF EMPLOYED REALTOR
16b. Kind of Business/Industry: REAL ESTATE

17. Father's Name (First, Middle, Last): HOWLETT CORNELIUS KLEINSTUBER
18. Mother's Name (First, Middle, Maiden Surname): ELLEN CAREY

19e. Informant's Name/Relationship (Type, Print): PRISCILLA R. KLEINSTUBER/WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 31 DAGSBORO STREET, FENWICK ISLAND, DELAWARE. 19944

20e. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MELSON'S CAPE HENLOPEN CREMATORY | Date: 08-09-99
20c. Location - City or Town, State: FRANKFORD, DELAWARE

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: MELSON FUNERAL SERVICES, LTD. WEST AVE. OCEAN VIEW, DELAWARE. 19970

Physician /Medical Examiner

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Liver (Hepatic) Failure
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Renal Failure
Due to (or as a consequence of):
c. Gastrointestinal Bleed
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24e. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28e. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jeffrey Matson MD
29c. License number: H00053714
29d. Date signed (Month, Day, Year): 08/02/1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Jeffrey Matson, DO 9714 Healthway Drive Berlin, MD 21811

State Registrar

31. Date filed (Month, Day, Year): AUG 05 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Kleinstuber, John F. 579-30-4948 8-2-99 9:37pm

25+1

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25560

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: RAJ KANSAL

2. Date of Death — Month: JULY — Day: 18 — Year: 1999

3. Time of Death: 4:02 P.M.

4a. Facility Name *(If not institution, give street and number)*: MEMORIAL HOSPITAL MEDICAL CENTER

4b. City, Town, or Location of Death: CUMBERLAND

4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 200-64-8675

6. Sex: XX M 2☐ F

7. Age *(In yrs. last birthday)*: 69 Yrs.

If Under 1 Year — Months: Days: If Under 24 Hrs. — Hours: Min.:

8. Date of Birth *(Month, Day, Year)*: MARCH 17 1930

9. Birthplace *(State or Foreign Country)*: INDIA

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ALLEGANY

10c. City, Town or Location: CUMBERLAND

10d. Inside City Limits: XX Yes 2☐ No

10e. Street and Number: 1054 RICHWOOD AVE.

10f. Zip Code: 21502

10g. Citizen of What Country?: INDIA

11. Meritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* OTHER ASIAN OR PACIFIC ISLANDER

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12+ — College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: ACCOUNTANT

16b. Kind of Business/Industry: ACCOUNTANT

17. Father's Name *(First, Middle, Last)*: CHHATTAR MAL

18. Mother's Neme *(First, Middle, Meiden Surneme)*: TRIVENI DEVI

19a. Intorment's Name/Relationship *(Type, Print)*: DR SUNIL K. GUPTA SON IN LAW

19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1054 RICHWOOD AVE CUMBERLAND MARYALAND 21502

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, cremetory or other place)*: CUMBERLAND CREMATORY

Date: JULY 20 1999

20c. Location - City or Town, State: CUMBERLAND MARYLAND

21. Signature of Funeral Service Licensee: Dale L. Merritt

22. Name end Address of Facility: MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode ot dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one ceuse on aach line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CHOLANGIOCARCINOMA — 1 YEAR

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the causa of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, snd due to the cause(s) and manner stated.

29b. Signatura and title of certifier: [signature]

29c. License number: D33280

29d. Date signed *(Month, Day, Year)*: July 19 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. SUNIL GUPTA, JOHNSON HEIGHTS MEDICAL BUILDING, 625 KENT AVENUE, CUMBERLAND, MD

State Registrar

31. Date filed *(Month, Day, Year)*: JUL 21 1999

32. Registrar's Signeture: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, (200-64-8675)

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

RHA KANSAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25561

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Edward C. Kipe Sr.

2. Date of Death Month / Day / Year: July 26 1999

3. Time of Death: 0300

4a. Facility Name *(If not institution, give street and number)*: 12523 Goldens Avenue, SE

4b. City, Town, or Location of Death: Cumberland

4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 217-18-4658

6. Sex: 1☐ M 2☐ F — X

7. Age *(In yrs. last birthday)*: 75 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jun 28, 1924

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD

10b. County: Allegany

10c. City, Town or Location: Cumberland

10d. Inside City Limits: 1☐ Yes 2☐ No — X

10e. Street and Number: 12523 Goldens Avenue

10f. Zip Code: 21502

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No — If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☐ No — X — *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Retired Carman

16b. Kind of Business/Industry: CSX Transportation

17. Father's Name *(First, Middle, Last)*: Wesley J. Kipe

18. Mother's Name *(First, Middle, Maiden Surname)*: Fannie (Bartik)

19a. Informant's Name/Relationship *(Type, Print)*: Barbara Davis daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 15600 Cresap Mill Rd;Oldtown MD 21555

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Davis Memorial Cemeter

Date: 7/29/

20c. Location - City or Town, State: Cumberland, MD

21. Signature of Funeral Service Licensee: Nicholas J. Scarpelli

22. Name and Address of Facility: Scarpelli Funeral Home P.A. Cumberland, Maryland 21502

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDIAL INFARCTION — 5 minutes

Due to (or as a consequence of):

b. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE — 10 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Bernard Wonya

29c. License number: DO9831

29d. Data signed *(Month, Day, Year)*: 726 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DUVALS MANGER 11611 BEALLS RIDGE Clarks MD

State Registrar

31. Date filed *(Month, Day, Year)*: JUL 28 1999

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25562

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): KATHLEEN ALICE KIRBY
2. Date of Death (Month, Day, Year): July 30, 1999
3. Time of Death: 2033 PM
4a. Facility Name (If not institution, give street and number): Memorial Hospital & Medical Center
4b. City, Town, or Location of Death: Cumberland
4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 213-80-6530
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JUNE 1 1914
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ALLEGANY
10c. City, Town or Location: ELLERSLIE
10d. Inside City Limits: 1☐ Yes 2☒ No
10a. Street and Number: 14227 GARDNER AVE.
10f. Zip Code: 21529
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - American Indian, Bleck, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOUSE KEEPER
16b. Kind of Business/Industry: HOUSE KEEPER

17. Father's Neme (First, Middle, Last): LOUIS BEAL
18. Mother's Neme (First, Middle, Maiden Surneme): REBECCA ALBRIGHT

19a. Informant's Name/Reletionship (Type, Print): GRACE M. RINGER
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code): DAUGHTER P.O.BOX# 352 ELLERSLIE, MARYLAND 21529

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removel from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): REST LAWN CEMETERY
Date: AUGUST 3 1999
20c. Location - City or Town, State: LAVALE, MARYLAND

21. Signature of Funerel Service Licensee: ▶ Dale L. Merritt
22. Name and Address of Fecility: MERRITT-ADAMS FUNERAL HOME P.A. 404 DECATUR STREET CUMBERLAND MARYLAND

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert feilure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediete Cause (Final disease or condition resulting in death)	a. INTRAPARENCHYMAL CEREBRAL BLEEDING	FIVE DAYS
	Due to (or as e consequence of):	
Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or es a consequence ot):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditione** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an eutopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No
26. Piece of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end place, and dua to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: ▶ [signature]
29c. License number: D-14865
29d. Date signed (Month, Day, Year): JULY 31, 1999

30. Name and address of person who completed cause ot death (Item 23a) (Type, Print): DR. ROBUSTIANO J. BARRERA MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND MD.

State Registrar

31. Date filed (Month, Day, Year): August 2, 1999
32. Registrar's Signature: ▶ Geneva Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

KATHLEEN KIRBY 213-80-6530

6

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25563

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DAVID J. LICHTY
2. Date of Death (Month, Day, Year): July 25, 1999
3. Time of Death: 2:25 A.M.
4a. Facility Name (If not institution, give street and number): Memorial Hospital & Medical Center
4b. City, Town, or Location of Death: Cumberland
4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 194-03-3620
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 84 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MAY 7, 1915
9. Birthplace (State or Foreign Country): PENNSYLVANIA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ALLEGANY
10c. City, Town or Location: CUMBERLAND
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 40 HUMBIRD STREET
10f. Zip Code: 21502
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+): 1
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CUSTODIAN
16b. Kind of Business/Industry: EDUCATION

17. Father's Name (First, Middle, Last): JONAS SIMON LICHTY
18. Mother's Name (First, Middle, Maiden Surname): LELA MYRTLE SCHRAMM

19a. Informant's Name/Relationship (Type, Print): JAMES LICHTY/NEPHEW
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1010 GREEN HILL FARM RD, REISTERSTOWN, MD

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ROCKY GAP VETERANS CEM
Date: JULY 28, 1999
20c. Location - City or Town, State: 21136 FLINTSTONE, MD

21. Signature of Funeral Service Licensee: Douglas L. Hafer
22. Name and Address of Facility: HAFER FUNERAL HOME 1302 NATIONAL HWY, LAVALE, MD 21502

Physician /Medical Examiner

23a. Part I. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. CHF acute and chronic — 7 years
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end placa, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Per William Lamm, M.D.
29c. License number: D 25406
29d. Date signed (Month, Day, Year): July 31, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William Lamm, M.D., 47 Virginia Avenue, Cumberland, MD 21502

State Registrar

31. Date filed (Month, Day, Year): AUG 0 2 1999
32. Registrar's Signature: Patricia G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

194-03-3620

David Lichty

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Amended #18 7/22/99
Allegany County mcv

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25564

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Patricia	C.	Lineburg	Jul 18, 1999	06:10pm

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
213 Virginia Avenue	Cumberland	Allegany

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-20-5182	1☐M 2☒F	75 Yrs.			Oct 21, 1923	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Allegany	Cumberland	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
213 Virginia Avenue	21502	USA

11. Marital Status	12. Wes Decedent Evar in U.S. Armed Forcas?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Bleck, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Yaar or Datas:	1☐Yes 2☒No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Retired Salesperson	Shoe Sales

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Frank Herbaugh	Faye G (~~Shanholtz~~) Shanholtzer

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Debbie Gattian niece	Route 7 Box 25;Fairmont, WV 26554

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other piece)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremetion 3☐Ramovel from State 4☐Donetion 5☐Other (Specify)	Wesley Chapel Cemetery	7/23/	Points, WV

21. Signature of Funeral Servica Licensee	22. Name and Address of Facility
▶ Nicholas J. Scarpelli	Scarpelli Funeral Home P.A. Cumberland, Maryland 21502

Physician /Medical Examiner

23a. Part1. Entar the disease, or complications thet caused the daath. Do not entar the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

		Approximete Interval Between Onset end Death
Immedieta Cause (Final diseese or condition resulting in deeth)	e. Arteriosclerotic Heart Disease	unknown
	Due to (or es a consequence of):	
Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last	b.	
	Due to (or es e consequence of):	
	c.	
	Due to (or es a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Wes an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Wes case referred to medical examiner?	26. Place of Death (Check only one)	
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Routa Number, City or Town, Stete)

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date and piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Paul Snow M.D.	D09157	Jul 18, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Paul Snow M.D. 124 W. 3rd Street Cumberland MD 21502

State Registrar

31. Dete filed (Month, Day, Year)	32. Registrar's Signeture
JUL 22 1999	Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

mcv 5

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended Item#1 per FR G774 8/13/99 EW

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25565

Physician /Medical Examiner

1. Decedent's Nema (First, Middle, Lest): ROBERT L. LOGESTON

2. Date of Daath — Month: July; Dey: 19; Yaar: 1999

3. Tima of Death: 03:15

4a. Facility Nama (If not institution, giva street and number): LIONS MANOR NURSING HOME

4b. City, Town, or Location of Death: CUMBERLAND

4c. County of Death: ALLEGANY

Funeral Director

5. Social Sacurity Numbar: 176-14-7083

6. Sax: 1 [X] M 2 [ ] F

7. Aga (In yrs. last birthday): 84 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Yaar): JUNE 17, 1915

9. Birthplaca (Stata or Foreign Country): PENNSYLVANIA

Usual Residanca of Dacedent

10a. State: MARYLAND

10b. County: ALLEGANY

10c. City, Town or Location: FLINTSTONE

10d. Inside City Limits: 1 [ ] Yas 2 [X] No

10e. Street and Number: GAP ROAD

10f. Zip Code: 21530

10g. Citizan of What Country?: USA

11. Marital Status: 1 [ ] Naver Marriad 2 [ ] Married 3 [X] Widowad 4 [ ] Divorcad

12. Was Decedant Ever in U.S. Armed Forces? 1 [X] Yas 2 [ ] No. If Yas, Giva Yaar or Dates: WW II

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 1 [ ] Yas 2 [X] No Specify:

14. Raca - American indian, Black, Whita, etc. Specify: WHITE

15. Decedant's Education (Specify only highest grada complatad): Elamentary/Secondary (0-12): 8; Collaga (1-4or 5+):

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired): MAIL CARRIER

16b. Kind of Businass/Industry: US GOVERNMENT

17. Fathar's Nema (First, Middle, Last): CHARLES LOGESTON

18. Mothar's Nama (First, Middle, Maiden Surnama): GEORGIE BENNETT

19a. Informant's Name/Ralationship (Type, Print): RODNEY A. LOGESTON/SON

19b. Mailing Addrass (Straat and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda): 14200 FORSYTHIA LANE, FLINTSTONE, MD 21530

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Removal from Stata 4 [ ] Donation 5 [ ] Othar (Specify)

20b. Placa of Disposition (Nama of cematary, cramatory or othar placa): FLINTSTONE I.O.O.F. CEMETERY

Data: JULY 21, 1999

20c. Location - City or Town, Stata: FLINTSTONE, MD

21. Signature of Funaral Servica Licansee: Douglas S. Hafer

22. Nama and Addrass of Facility: HAFER CHAPEL OF THE HILLS MORTUARY, 1302 NATIONAL HWY, LAVALE, MD 21502

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that caused tha daath. Do not anter the moda of dying, such as cardiac or raspiratory arrast, shock, or heart failura. List only ona causa on aach lina.

Approximata Intarval Batwaan Onsat and Death

Immadiata Causa (Final disaasa or condition resulting in daath):
- e. Respiratory failure — few hours
- Dua to (or as a consaquanca of):
- b. Severe C.O.P.D. — 1 year.
- Dua to (or as a consaquanca of):

Saquantially list conditions, if any, laading to immadiata cause. Entar Undarlying Causa (Disaasa or Injury that initiatad avants resulting in daath) Last:
- c.
- Dua to (or as a consaquanca of):
- d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying cause given in Part I.: C.H.F, Diabetis Mellitus type II, Chronic A.F, depression, Cardiomegaly liver metastatis - IV unknown D.V.T

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy parformad? 1 [ ] Yas 2 [X] No

24b. Wara autopsy findings availabla prior to complation of cause of daath? 1 [ ] Yas 2 [ ] No

25. Was casa rafarrad to medical examinar? 1 [ ] Yas 2 [X] No

26. Placa of Daath (Check only ona): Hospital: 1 [ ] Inpatiant 2 [ ] ER/Outpatiant 3 [ ] DOA; Othar: 4 [X] Nursing Home 5 [ ] Rasidanca 6 [ ] Othar (Specify)

27. Manar of Daath: 1 [X] Naturel 2 [ ] Accidant 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Pending invastigation 6 [ ] Could not be datarmined

28a. Data of Injury (Month, Day Yaar)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yas 2 [ ] No

28d. Describa how injury occurrad

28a. Placa of injury - At home, farm, straat, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledga, daath occurrad at tha time, data and placa, and due to the causa(s) and manner as stated. 2 [ ] **Medical Examiner**: On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar stated.

29b. Signatura and title of cartifiar: V.A. Ranjithan

29c. License number: D 19750

29d. Data signed (Month, Day, Yaar): July 19, 1999

30. Nama and addrass of parson who complatad causa of daath (Item 23a) (Type, Print): V.A. Ranjithan, M.D., Lions Manor Nursing Home, Seton Drive Extended., Cumberland MD 21502

State Registrar

31. Data filed (Month, Day, Yaar): JUL 21 1999

32. Registrar's Signatura: Geneva G. Jones

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

MV 3 (1/94)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25566

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Harry B. Lewis, Sr.

2. Date of Death — Month: July; Day: 24; Year: 1999

3. Time of Death: 01:15 PM

4a. Facility Name *(If not institution, give street and number)*: Saint Vincent DePaul Nursing Center

4b. City, Town, or Location of Death: Frostburg

4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 213-03-0910

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 83 Yrs.

If Under 1 Year — Months: ; Days:

If Under 24 Hrs. — Hours: ; Min.:

8. Date of Birth *(Month, Day, Year)*: 29-Jun-16

9. Birthplace *(State or Foreign Country)*: Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Allegany

10c. City, Town or Location: Eckhart

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 10403 Eckhart Mines Street, S.W.

10f. Zip Code: 21528-

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Yeer or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*

Elementery/Secondary (0-12): 12

College (1-4or 5+): 0

16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: powder mechinist

16b. Kind of Business/Industry: ballistics laboratory

17. Father's Neme *(First, Middle, Last)*: Samuel Lewis

18. Mother's Neme *(First, Middle, Meiden Sumeme)*: Annie Bamard

19e. Informent's Name/Reletionship *(Type, Print)*: Mary U. Lewis Wife

19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 81 East Mechanic Street Frostburg Maryland 21532-

20e. Method of Disposition: 1 [ ] Buriel 2 [X] Cremetion 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Cumberland Crematory

Dete: 27-Jul-99

20c. Location - City or Town, Stete: Cumberland, Maryland

21. Signature of Funeral Service Licensee: John R Durst

22. Neme end Address of Feclility: Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Deeth

Immediete Cause (Final diseese or condition resulting in deeth): e. ESOPHAGEAL CARCINOMA — 7 MO.

Due to (or es e consequence of):

Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in deeth) Lest

b.

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24e. Wes en autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings eveileble prior to completion of cause of deeth? 1 [ ] Yes 2 [X] No

25. Was case referred to medical exeminer? 1 [ ] Yes 2 [X] No

26. Piece of Deeth *(Check only one)*: Hospitel: 1 [ ] Inpetient 2 [ ] ER/Outpetient 3 [ ] DOA — Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Deeth: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28e. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury: M

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, offica building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Phyeician:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end manner es steted. 2 [ ] **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) end menner stated.

29b. Signeture end title of certifier: Robustiano J. Barrera

29c. License number: D-14865

29d. Date signed *(Month, Dey, Yeer)*: JULY 27TH, 1999

30. Neme end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print): Robustiano J. Barrera, M.D., Memorial Hospital Medical Building, Cumberland, Maryland 21502

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: JUL 27 1999

32. Registrer's Signeture: Virginia G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the **Hospital or Attending Physician:** The law requires thet the death certificate be executed within 24 hours eftar death.
To the **Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

5

MD

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25567

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EDWARD ARTHUR MAHASSEL

2. Date of Death: Month 7 Day 31 Year 99

3. Time of Death: 13:44

4a. Facility Name (If not institution, give street and number): ATLANTIC GENERAL HOSPITAL

4b. City, Town, or Location of Death: BERLIN

4c. County of Death: WORCESTER

Funeral Director

5. Social Security Number: 030-12-8841

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 6-7-25

9. Birthplace (State or Foreign Country): MA

Usual Residence of Decedent

10a. State: MD.

10b. County: WORCESTER

10c. City, Town or Location: OCEAN CITY

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 307 139TH STREET

10f. Zip Code: 21842

10g. Citizen of What Country: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): RESTAURANTEUR

16b. Kind of Business/Industry: HOSPITALITY

17. Father's Name (First, Middle, Last): ARTHUR MAHASSEL

18. Mother's Name (First, Middle, Maiden Surname): ANNE HAJJI

19a. Informant's Name/Reletionship (Type, Print): ANNE R. MAHASSEL SPOUSE

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 307 139TH ST., OCEAN CITY, MD., 21842

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): SALISBURY CREMATORY

Date: 8-2

20c. Location - City or Town, State: SALISBURY, MD.

21. Signature of Funeral Service Licensee: John Ullrich

22. Name and Address of Facility: ULLRICH FUNERAL HOME BERLIN, MD.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. anoxic encephelopathy — 1 week

Due to (or es e consequence of):
b. myocardial infarction — 12 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings avellable prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical exeminer? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Menner of Deeth: 1 ☒ Natural 2 ☐ Accident 3 ☐ Sulcide 4 ☐ Homicide 5 ☐ Pending Investigetion 6 ☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, dete end piece, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination end/or Investigation, In my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier: physician

29c. License number: H44283

29d. Date signed (Month, Day, Year): 7/31/99

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Robert Durkin 9733 Heelmuey Drive Berlin, MD

5th

State Registrar

31. Date filed (Month, Day, Year): AUG 0 2 1999

32. Registrer's Signeture: Geneva G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25568

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY E. MURRAY

2. Date of Death: Month AUGUST Day 1 Year 1999

3. Time of Death: 2312

4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 222-20-4914

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 83 Yrs.

If Under 1 Year: Months ____ Days ____

If Under 24 Hrs.: Hours ____ Min. ____

8. Date of Birth (Month, Day, Year): 07-22-1916

9. Birthplace (State or Foreign Country): DELAWARE

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: WORCESTER

10c. City, Town or Location: WHALEYVILLE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 9525 WHALEYSVILLE ROAD

10f. Zip Code: 21872

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER

16b. Kind of Business/Industry: NONE

17. Father's Name (First, Middle, Last): GEORGE W. WARRINGTON

18. Mother's Name (First, Middle, Maiden Surname): ADDIE W. LYNCH

19a. Informant's Name/Relationship (Type, Print): JANICE POWELL/ DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): RT.1 CUELEN ACRES #5, FRANKFORD, DELAWARE. 19945

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): MARINER'S BETHEL CEM.

Date: 08-04-99

20c. Location - City or Town, State: OCEAN VIEW, DELAWARE

21. Signature of Funeral Service Licensee

22. Name and Address of Facility: MELSON FUNERAL SERVICES, LTD. 43 THATCHER ST., FRANKFORD, DELAWARE. 19945

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) a. cerebral infarct — days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ____ Due to (or as a consequence of):

c. ____ Due to (or as a consequence of):

d. ____

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: 029749

29d. Data signed (Month, Day, Year): 8/2/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William Robins M.D. 1104 Healthway Dr. Salisbury, MD

State Registrar

31. Date filed (Month, Day, Year): AUG 05 1999

32. Registrar's Signature: Geneva D. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Mary E. Murray 222-20-4914

12

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25569

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARY MARGARET MASON

2. Date of Death Month Day Year: AUGUST 2, 1999

3. Time of Death: 5:45 AM

4a. Facility Name *(If not institution, give street and number)*: 909 HIGHVIEW DRIVE

4b. City, Town, or Location of Death: CAPITOL HEIGHTS

4c. County of Death: PRINCE GEORGE'S

Funeral Director

5. Social Security Number: 578-18-0516

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 78 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: APRIL 25, 1921

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: PRINCE GEORGE'S

10c. City, Town or Location: CAPITOL HEIGHTS

10d. Inside City Limits: 1☐ Yes 2☐ No

10a. Street and Number: 909 HIGHVIEW DRIVE

10f. Zip Code: 20743

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: SECRETARY

16b. Kind of Business/Industry: RETAIL

17. Father's Name *(First, Middle, Last)*: REGNALD CORNELL HANCOCK

18. Mother's Name *(First, Middle, Maiden Surname)*: LILLIAN MIRA CHESELDINE

19a. Informant's Name/Relationship *(Type, Print)*: MARLA GARNER/DAUGHTER

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 909 HIGHVIEW DRIVE, CAPITOL HEIGHTS, MD 20743

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: THE HUNTT CREMATORY

Date: AUGUST 3, 1999

20c. Location - City or Town, State: WALDORF, MARYLAND

21. Signature of Funeral Service Licensee: JPK ▶ JOHN P. KNISLEY MO1164

22. Name and Address of Facility: THE HUNTT FUNERAL HOME, INC., POST OFFICE BOX 156, WALDORF, MARYLAND 20604-0156

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Non-Hodgkin's Lymphoma — 6 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Bruce A. Silver, MD

29c. License number: 021463

29d. Date signed *(Month, Day, Year)*: 8-2-99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Bruce A. Silver, MD 110 Hospital Rd., Su. 110, Prince Frederick, MD. 20678

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 04 1999

32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Amended #20c, NLS, 8/4/99, Allegany County

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25570

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Mary J. Mowery	Aug. 2, 1999	5:15 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Devlin Manor Nursing Home	Cumberland	Allegany

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
183-44-0185	1☐ M 2☒ F	86 Yrs.			Jul. 23, 1913	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Allegany	Cumberland	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1 Yost Ave.	21502	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)	14. Race - American Indien, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
4		Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
James H. Johnson	Sarah E. (Rummer)

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Dorothy Johnson	1 Yost Ave., Cumberland, MD 21502

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Buriel 2☐ Cremation 3☐ Removal from Stete 4☐ Donation 5☐ Other (Specify)	Zion Memorial Park	8/4/99	Cumberland ~~Cumberland~~-MD

21. Signature of Funeral Service Licensee	22. Name end Address of Facility
William [illegible]	Kight Funeral Home 309-311 Decatur St., Cumberland, MD21502

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions thet caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heert failure. List only one cause on each line.

		Approximate Interval Between Onset end Death
Immediate Cause (Final disease or condition resulting in deeth)	a. Metastatic Carcinoma, Primary Undetermined (2 month)	June 99
Due to (or es a consequence of):		
Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last	b. Due to (or es e consequence of):	
	c. Due to (or as a consequence of):	
	d.	

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given In Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how Injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and manner as steted.
2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner steted.

29b. Signeture end title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
(1) Qamar Zaman MD	D23371	8-2-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
625 Kent Avenue, Suite 102, Cumberland MD 21502

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
AUG 04 1999	[illegible] G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5

MS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25571

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Melvin T. Moore Sr.
2. Date of Death (Month, Day, Year): 07 20 1999
3. Time of Death: 12:47 p.m.
4a. Facility Name (If not institution, give street and number): Memorial Hospital Medical Center
4b. City, Town, or Location of Death: Cumberland
4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 234-42-9514
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 69 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Apr 8, 1930
9. Birthplace (State or Foreign Country): WV

Usual Residence of Decedent

10a. State: WV
10b. County: Mineral
10c. City, Town or Location: Keyser
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: Route 2 Box 139D
10f. Zip Code: 26726
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? [X] Yes 2 [ ] No If Yes, Give Year or Dates: Korea
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Retired Employee
16b. Kind of Business/Industry: Steel Corporation

17. Father's Name (First, Middle, Last): John Moore
18. Mother's Name (First, Middle, Maiden Surname): Augusta (Cosner)

19a. Informant's Name/Relationship (Type, Print): Dorothy Moore wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): Route 2 Box 139D;Keyser WV 26726

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mineral Baptist Cemete
Date: 7/24/
20c. Location - City or Town, State: Keyser, WV

21. Signature of Funeral Service Licensee: Nicholas J. Scarpelli
22. Name and Address of Facility: Scarpelli Funeral Home P.A. Cumberland, Maryland 21502

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	SEPTIC SHOCK	72 hours
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b.	CHRONIC LYMPHOCYTIC LEUKEMIA	8 years
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D23371
29d. Date signed (Month, Day, Year): JULY 21, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Zaman, 625 Kent Avenue, Suite 102, Cumberland, Maryland 21502

State Registrar

31. Date filed (Month, Day, Year): JUL 22 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Melvin Moore 234-42-9514

mv 8

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25572

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Bessie	M.	Milburn	JULY 24th, 1999	0846 AM

4e. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Memorial Hospital	Cumberland	Allegany

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-34-6236	1☐ M 2☒ F	63 Yrs.			Jun 27, 1936	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Allegany	Cumberland	1☐ Yes 2☐ No X

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
923 Virginia Avenue Apt. 2	21502	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married X Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		homemaker	own home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John Thomas Winters II	Bessie M (Wampler)

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
James Reynolds friend	923 Virginia Avenue ;Cumberland MD 21502

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
X 1 Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Restlawn Memorial Gard	7/27/	LaVale, MD

21. Signature of Funeral Service Licensee: Nicholas J. Scarpelli

22. Name and Address of Facility: Scarpelli Funeral Home P.A. Cumberland, Maryland 21502

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Laryngeal Carcinoma	1 Yr years
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. tobacco use	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

none

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature] medical doctor	052056	07/26/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
ALBERT C. VILLANOSA, MD 925 BISHOP WALSH ROAD, CUMBERLAND, MD 21502

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 27 1999	[signature]

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

MILBURN, BESSIE M. 219-34-6236

6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25573

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Harriet F. McKenzie
2. Date of Death Month Day Year: July 31, 1999
3. Time of Death: 6:49 PM
4a. Facility Name *(If not institution, give street and number)*: 800 Trost Ave.
4b. City, Town, or Location of Death: Cumberland
4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 215-36-9459
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 84 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Oct. 1, 1914
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Allegany
10c. City, Town or Location: Cumberland
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 800 Trost Ave.
10f. Zip Code: 21502
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates: X
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:* X
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 3
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Case Worker
16b. Kind of Business/Industry: State Social Services

17. Father's Name *(First, Middle, Last)*: Philip T. Carolan, Sr.
18. Mother's Name *(First, Middle, Maiden Surname)*: Gertrude P. (Speelman)

19a. Informant's Name/Relationship *(Type, Print)*: Leonard A. McKenzie, Jr.
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 12305 Gramlich Rd., SW, LaVale, MD 21502

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: St. Patricks Cemetery — Date: 8/4/99
20c. Location - City or Town, State: Cumberland, MD

21. Signature of Funeral Service Licensee: William P. Knight
22. Name and Address of Facility: Kight Funeral Home 309-311 Decatur St., Cumberland, MD 21502

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List *only* one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pancreatic Cancer — 1 year

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No X
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: J. Poonai
29c. License number: D36766
29d. Date signed *(Month, Day, Year)*: August 1, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Vikramaditya Poonai, M. D., 920 National Highway, LaVale, MD 21502

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 0 2 1999
32. Registrar's Signature: G. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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MS

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25574

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Anita Marie Natale
2. Date of Death (Month, Day, Year): Jul 29, 1999
3. Time of Death: 03:25am
4a. Facility Name (If not Institution, give street and number): 202 N. Centre Street
4b. City, Town, or Location of Death: Cumberland
4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 219-44-2256
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 70 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct 9, 1928
9. Birthplace (State or Foreign Country): WV

Usual Residence of Decedent

10a. State: MD
10b. County: Allegany
10c. City, Town or Location: Cumberland
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 202 N. Centre Street
10f. Zip Code: 21502
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own home

17. Father's Name (First, Middle, Last): Cecil Blackburn
18. Mother's Name (First, Middle, Maiden Surname): Cleda (nmn)

19a. Informant's Name/Relationship (Type, Print): Robert C. Natale son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 18713 Shremor Drive;Derwood, MD 20855

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Cumberland Crematory
Date: 7/29/
20c. Location - City or Town, State: Cumberland, MD

21. Signature of Funeral Service Licensee: Nicholas J. Scarpelli
22. Name and Address of Facility: Scarpelli Funeral Home P.A. Cumberland, Maryland 21502

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Malignant Melanoma — 1 1/2 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D09157
29d. Date signed (Month, Day, Year): Jul 29, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Paul Snow M.D. 124 W. 3rd Street Cumberland MD 21502

State Registrar

31. Date filed (Month, Day, Year): JUL 30 1999
32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25575

Certificate of Death Reg. No.

Pietruszka, Daniel E. 6/4/0. w.m. 219-26-4953 a/a/38 - 7/29/99 a) 1414

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
DANIEL	E.	PIETRUSZKA	7	29	99	1414

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
ATLANTIC GENERAL HOSPITAL	BERLIN	WORCESTER

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-26-4953	1☒ M 2☐ F	61 Yrs.					2-2-38	MD.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	WORCESTER	OCEAN CITY	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
529 HARBOR DRIVE	21842	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No *Specify:*	*Specify:* WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		SUPERVISOR	UTILITY

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
JOSEPH PIETRUSZKA	EVA SKRUCHA

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MARLYN E. PIETRUSZKA/SPS	529 HARBOR DRIVE OCEAN CITY, MD. 21842

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	ST. STANISLAUS CEM.	8-3-99	BALTIMORE, MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ John D. Ullrich	ULLRICH FUNERAL HOME BERLIN, MD. 21811

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Cardiac Arrhythmia	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ J McShea D.O.	H51718	7/29/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

6 Joseph B McShea 10514 Racetrack Rd, Unit C, Berlin MD 21811

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 30 1999	Jeanne G. Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25576

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Lest): Glocia Pappas
2. Date of Death: Month: Augnst Day: 1 Year: 1999
3. Time of Death: 09:45 AM
4a. Facility Name (If not institution, give street end number): HOSPICE OF THE CHESAPEAKE
4b. City, Town, or Location of Deeth: LINTHICUM
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 215-36-8796
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. lest birthdey): 58 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Year): OCT 17, 1940
9. Birthplece (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10e. Stete: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: GLEN BURNIE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 7006 CRESTHAVEN DRIVE
10f. Zip Code: 21061
10g. Citizen of What Country?: USA

11. Merital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Educetion (Specify only highest grede completed): Elementary/Secondery (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): MANAGER
16b. Kind of Business/Industry: WASTE WATER TREATMENT

17. Fether's Name (First, Middle, Last): MILBURN A. MICHAEL, SR.
18. Mother's Name (First, Middle, Maiden Surneme): ETHEL G. KESSELL

19a. Informent's Neme/Reletionship (Type, Print): FRANK N. PAPPAS/HUSBAND
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 7006 CRESTHAVEN DR., GLEN BURNIE, MD 21061

20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removel from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other place): REST LAWNMEMORIAL GARDENS | Dete: AUG 4, 1999
20c. Location - City or Town, Stete: LAVALE, MD 21502

21. Signeture of Funerel Service Licensee: Douglas S. Hafer
22. Name and Address of Fecility: HAFER CHAPEL OF THE HILLS MORTUARY 1302 NATIONAL HWY, LAVALE, MD 21502

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Gloria Pappas

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

Approximate Intervel Between Onset end Death

Immediate Ceuse (Final disease or condition resulting in death): e. BRAIN TUMOR (Astrocytoma) — 2 yrs.
Due to (or es e consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury thet initieted events resulting in deeth) Lest:
b. Due to (or as e consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the ceuse of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Was en eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings eveileble prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Plece of Deeth (Check only one): Hospital: 1☐ Inpetient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice House Chesapeake

27. Menner of Deeth: 1☒ Neturel 2☐ Aocident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) and menner as stated. 2☐ **Medical Examiner:** On the besis of exemineticn and/or Investigetion, In my opinion, death occurred at the time, date end plece, end due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: Russell A. Pellegrino MD
29c. License number: 031551
29d. Dete signed (Month, Dey, Year): August 2, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Russell A. Pellegrino MD 1600 S. Crain Hwy, Suite 602, Glen Burnie, MD 21061

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

MS

State Registrar

31. Dete filed (Month, Dey, Year): AUG 03 1999
32. Registrar's Signature:

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25577

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Wanda Lee Partlow
2. Date of Death (Month, Day, Year): July 27, 1999
3. Time of Death: 13:55
4a. Facility Name (If not institution, give street and number): MEMORIAL HOSPITAL
4b. City, Town, or Location of Death: CUMBERLAND
4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 212-24-1330
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 70 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov 7, 1928
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Allegany
10c. City, Town or Location: Cumberland
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 25 Hawthorne Avenue
10f. Zip Code: 21502
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Retired General Manager Credit Union
16b. Kind of Business/Industry:

17. Father's Name (First, Middle, Last): Robert Parsons
18. Mother's Name (First, Middle, Maiden Surname): Effie (Hamilton)

19a. Informant's Name/Relationship (Type, Print): William V Partlow, Sr. husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 25 Hawthorne Avenue;Cumberland MD 21502

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Rocky Gap Veterans Cem
Date: 7/29/
20c. Location - City or Town, State: Flintstone, MD

21. Signature of Funeral Service Licensee: Nicholas J. Scarpelli
22. Name and Address of Facility: Scarpelli Funeral Home P.A. Cumberland, Maryland 21502

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Massive myocardial infarction — <48 hours

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Terry Williams MD
29c. License number: D16041
29d. Date signed (Month, Day, Year): July 27 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): TERRY WILLIAMS,M.D., MEMORIAL MEDICAL BUILDING CUMBERLAND MD 21502

State Registrar

31. Date filed (Month, Day, Year): JUL 29 1999
32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that this death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

WANDA PARTLOW 212-24-1330

4/12 MS

ORIGINAL

Amended #16a, MLS, 8/3/99, Allegany County

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25578

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MAX PERLIS

2. Date of Death Month / Day / Year: JULY 30 1999

3. Time of Death: 4:35 PM

4a. Facility Name *(If not institution, give street and number)*: 1 BALTIMORE STREET

4b. City, Town, or Location of Death: CUMBERLAND

4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 384-18-7868

6. Sex: ☒ 1 M ☐ 2 F

7. Age *(In yrs. last birthday)*: 91 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: SEPT 6, 1907

9. Birthplace *(State or Foreign Country)*: UNKNOWN

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ALLEGANY

10c. City, Town or Location: CUMBERLAND

10d. Inside City Limits: ☒ 1 Yes ☐ 2 No

10e. Street and Number: 1 BALTIMORE STREET

10f. Zip Code: 21502

10g. Citizen of What Country?: USA

11. Marital Status: ☒ 1 Never Married ☐ 2 Married ☐ 3 Widowed ☐ 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? ☒ 1 Yes ☐ 2 No — If Yes, Give Year or Dates: 1942-1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): ☐ 1 Yes ☒ 2 No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: ~~ENTERTAINER~~ Entertainer

16b. Kind of Business/Industry: CIRCUS

17. Father's Name *(First, Middle, Last)*: DAVID PERLIS

18. Mother's Name *(First, Middle, Maiden Surname)*: SARA BAUM

19a. Informant's Name/Relationship *(Type, Print)*: MARTHA SHADE/FRIEND

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1 BALTIMORE ST., CUMBERLAND, MD 21502

20a. Method of Disposition: ☒ 1 Burial ☐ 2 Cremation ☐ 3 Removal from State ☐ 4 Donation ☐ 5 Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: EASTVIEW CEMETERY

Date: AUG 1,1999

20c. Location - City or Town, State: CUMBERLAND, MD

21. Signature of Funeral Service Licensee: Douglas S. Hafer

22. Name and Address of Facility: HAFER CHAPEL OF THE HILLS MORTUARY 1302 NATIONAL HWY, LAVALE, MD 21502

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Pancreatic Cancer — 6 mnths

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? ☐ 1 Yes ☐ 2 No ☐ 3 Probably ☒ 4 Unknown

24a. Was an autopsy performed? ☐ 1 Yes ☒ 2 No

24b. Were autopsy findings available prior to completion of cause of death? ☐ 1 Yes ☒ 2 No

25. Was case referred to medical examiner? ☐ 1 Yes ☒ 2 No

26. Place of Death *(Check only one)*: Hospital: ☐ 1 Inpatient ☐ 2 ER/Outpatient ☐ 3 DOA — Other: ☐ 4 Nursing Home ☒ 5 Residence ☐ 6 Other *(Specify)*

27. Manner of Death: ☒ 1 Natural ☐ 2 Accident ☐ 3 Suicide ☐ 4 Homicide ☐ 5 Pending investigation ☐ 6 Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury: M

28c. Injury at Work? ☐ 1 Yes ☐ 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: ☐ 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D36766

29d. Date signed *(Month, Day, Year)*: AUG 2, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): DR. VIKRAMADITYA POONAI, 920 NATIONAL HWY, LAVALE, MD 21502

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 3 1999

32. Registrar's Signature: Virginia D. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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MLS

DHMH 16 Rev 6/95

99-4477-510
jhm
TRAVIS
POWELSON

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25579

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): TRAVIS MICHAEL POWELSON
2. Date of Death Month Day Yeer: JULY 30, 1999
3. Time of Death: 06:07 AM
4a. Facility Name (If not Institution, give street and number): JOHNS HOPKINS HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 233-45-2349
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. lest birthdey): 2 Yrs. — If Under 1 Yaar: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Year): MAY 16, 1997
9. Birthplece (State or Foreign Country): MARYLAND

Usuel Residence ot Decedent

10a. Steta: MD
10b. County: ALLEGANY
10c. City, Town or Location: OLDTOWN
10d. Insida City Limits: 1 [X] Yes 2 [ ] No
10e. Street end Number: 14811 BEAR HILL ROAD, S.E.
10f. Zip Code: 21555
10g. Citizen of What Country?: U.S.A.

11. Maritel Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedant Evar in U.S. Armed Forces? 1 [ ] Yes 2 [X] No — If Yes, Give Yeer or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yas, specify Cuben, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - Amarican Indien, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grede completed): Elemantary/Secondery (0-12): 0 — College (1-4or 5+):
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): NONE
16b. Kind of Businass/Industry: NONE

17. Fether's Nema (First, Middle, Last): ROBERT MICHAEL POWELSON
18. Mother's Name (First, Middle, Maiden Surneme): MARICAY RENEE HEDRICK

19a. Informant's Name/Relationship (Type, Print): MARICAY POWELSON/MOTHER
19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Code): 14811 BEAR HILL ROAD, S.E., OLDTOWN, MD 21555

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from Stete 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Piece of Disposition (Name of cemetery, cremetory or other piece): SUNSET MEMORIAL PARK — Date: 8/4/99
20c. Location - City or Town, Stete: CUMBERLAND, MD

21. Signature of Funerel Servica Licansaa: Wendy M. Upchurch
22. Name and Addrass of Facility: UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD 21502

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the deeth. Do not enter tha mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one ceusa on eech lina. — Approximete Interval Betwaen Onsat and Death

Immediete Ceuse (Final diseese or condition resulting in deeth):
a. Drowning
Due to (or as a consequance of):
b.
Sequantially list conditions, if eny, leeding to immediete cause. Entar Underlying Cause (Disaase or injury that initieted events resulting in deeth) Last
Due to (or as a consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were eutopsy findings avellable prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case retarred to medical examiner? 1 [X] Yes 2 [ ] No
26. Plece of Death (Check only one) — Hospitel: 1 [X] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Othar (Specify)
27. Manner of Death: 1 [ ] Naturel 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigetion 6 [ ] Could not be determined
28a. Dete of Injury (Month, Dey Year): 7-29-99
28b. Time of Injury: unknown M
28c. Injury et Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: subject fell into pool
28e. Place of Injury - At home, term, street, fectory, offica building, etc. (Specify): Residence
28f. Location (Street and Number or Rurel Route Number, City or Town, State): 14811 Bear Hill Road Cumberland, Maryland

29a. Certifier (Check only one): 1 [ ] **Certifying Physician**: To tha best of my knowledge, deeth occurred et the time, deta and piece, and due to tha cause(s) end menner es stated. 2 [X] **Medical Examiner**: On tha besis of exeminetion end/or investigation, in my opinion, deeth occurred at tha tima, dete and pleca, end due to the causa(s) end manner stated.
29b. Signatura end title of certifiar: Stephen S. Radentz, MD
29c. Licensa number: OCME
29d. Dete signed (Month, Day, Year): JULY 31, 1999
30. Nema end address of person who completed causa of death (Item 23a) (Type, Print): Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Day, Year): AUG 04 1999
32. Registrar's Signeture: Linda G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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MS

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25580

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Alma Vinora Price

2. Date of Death (Month, Day, Year): July 29, 1999

3. Time of Death: 7:25 p.m.

4a. Facility Name (If not institution, give street and number): Memorial Hospital & Medical Center

4b. City, Town, or Location of Death: Cumberland

4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 217-03-7454

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 17, 1918

9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Md

10b. County: Allegany

10c. City, Town or Location: Westernport

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 325 Maryland Avenue

10f. Zip Code: 21562

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): Griffith H. Whiteman

18. Mother's Name (First, Middle, Maiden Surname): Nettie Combs

19a. Informant's Name/Relationship (Type, Print): Teri Lea Price / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 507 White Surf Dr. Gaithersburg, MD 20878

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Arlington National Cemetery | Date: 8/4/99 | 20c. Location - City or Town, State: Arlington, VA

21. Signature of Funeral Service Licensee: ▶ F. Wayne Boal

22. Name and Address of Facility: Boal Funeral Home, 111 Church St. Westernport, MD 21562

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. RENAL FAILURE — 1 week

Due to (or es a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. ARTHROSCLEROSIS — 2 years

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29e. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶

29c. License number: D 36766

29d. Date signed (Month, Day, Year): July 30, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Vik Poonai, M.D., 920 National Highway, Cumberland, MD 21502

State Registrar

31. Date filed (Month, Day, Year): AUG 04 1999

32. Registrar's Signature: ▶ Donna G. Sparks

Division of Vital Records, P.O. Box 68760, 217-03-7454

Alma Price

12

225

DHMH 16 Rev 6/95

ORIGINAL

99-4639-033
CJ
Eric Patton

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #23 PART I, 27 PER MEO G775 9-10-99 WR.

Certificate of Death

Reg. No. 99 25581

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Eric Richard Patton
2. Date of Death: Month August, Dey 09, Year 1999
3. Time of Daeth: 08:54 PM.
4a. Facility Name (If not institution, give street and number): Prince George's Hospital Center
4b. City, Town, or Location of Death: Cheverly
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 213-02-3867
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthday): 29 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): Aug. 21, 1969
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Joppa
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 259 Foster Knoll Drive
10f. Zip Code: 21085
10g. Citizen of Whet Country?: USA

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Rece - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Meat Cutter
16b. Kind of Business/Industry: Grocery

17. Father's Name (First, Middle, Last): Richard Knox Patton
18. Mother's Neme (First, Middle, Meiden Surname): Robertina (NMN) Castillo

19a. Informant's Name/Relationship (Type, Print): Richard K. Patton/Father
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 259 Foster Knoll Drive, Joppa, MD 21085

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Trinity Lutheran Cem.
Date: 8/13/99
20c. Location - City or Town, State: Joppa, Maryland

21. Signeture of Funeral Service Licensee: [signature]
22. Name and Address of Facility: McComas Funeral Home, P,A. 1317 Cokesbury Road, Abingdon, MD 21009

Physician /Medical Examiner

23a. Part I. Enter the diseases, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Deeth

Immediate Cause (Finat disease or condition resulting in death)
a. CARDIAC ARRHYTHMIA
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contributa to the causa of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Wes en eutopsy performed? 1☒Yes 2☐No

24b. Were eutopsy findings available prior to completion of ceuse of deeth? 1☒Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No

26. Place of Deeth (Check only one): Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☐**Certifying Physician**: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) end menner as stated. 2☒**Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dennis J Clute on
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): August 10, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dennis Chuteau 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): SEP 9 1999
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25582

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: BURTON M. RICHARDS

2. Date of Death (Month, Day, Year): AUGUST 4, 1999

3. Time of Death: 0430

4a. Facility Name *(If not institution, give street and number)*: ATLANTIC GENERAL HOSPITAL

4b. City, Town, or Location of Death: BERLIN

4c. County of Death: WORCESTER

Funeral Director

5. Social Security Number: 579-18-1147

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 78 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 7-25-21

9. Birthplace *(State or Foreign Country)*: VA

Usual Residence of Decedent

10a. State: MD.

10b. County: WORCESTER

10c. City, Town or Location: BISHOPVILLE

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 13222 MUSKRATTOWN RD.

10f. Zip Code: 21813

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): / College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: MANAGER

16b. Kind of Business/Industry: UTILITY

17. Father's Name *(First, Middle, Last)*: WILLIAM B. RICHARDS

18. Mother's Name *(First, Middle, Maiden Surname)*: ALMA DAVIS

19a. Informant's Name/Relationship *(Type, Print)*: MARY C. RICHARDS SPOUSE

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 13222 MUSKRATTOWN RD. BISHOPVILLE, MD. 21813

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: GARDENS OF THE PINES Date: 8-7

20c. Location - City or Town, State: OCEAN PINES, MD.

21. Signature of Funeral Service Licensee: John C. Ullrich

22. Name and Address of Facility: ULLRICH FUNERAL HOME BERLIN, MD.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. GASTROINTESTINAL BLEED

Due to (or as a consequence of):
b. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. PERIPHERAL VASCULAR DISEASE

Due to (or as a consequence of):
d. LARYNGEAL MASS

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D46257

29d. Date signed *(Month, Day, Year)*: 8/4/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 9704 Heatherway Drive Berlin, MD 21811

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 05 1999

32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the **Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

To the **Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

8/4/99 0430

Burton Richards SS#579-18-1147

10H1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25583

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JAMES WILSON ROBINETTE

2. Date of Death Month Day Year: JULY 29 1999

3. Time of Death: 9:10 PM

4a. Facility Name (If not institution, give street and number): 11220 OLD MT. PLEASANT ROAD N.E.

4b. City, Town, or Location of Death: CUMBERLAND

4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 212-32-8013

6. Sex: 1☐M 2☐F XX

7. Age (In yrs. last birthday): 65 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JUNE 4 1934

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ALLEGANY

10c. City, Town or Location: CUMBERLAND

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 11220 OLD MT. PLEASANT ROAD N.E.

10f. Zip Code: 21502

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☒Married XX 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates: U.S. ARMY

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No X Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): U.S.ARMY SIGNAL CORPS

16b. Kind of Business/Industry: U.S ARMY

17. Father's Name (First, Middle, Last): MELVIN DEWEY ROBINETTE

18. Mother's Name (First, Middle, Maiden Surname): UNA URILLA TWIGG

19a. Informant's Name/Relationship (Type, Print): MARY ROBINETTE WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11220 OLD MT PLEASANT ROAD N.E. CUMBERLAND MD.21502

20a. Method of Disposition: 1☒Burial XX 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): PLEASANT GROVE CEMETERY

Date: AUG 2 1999

20c. Location - City or Town, State: CUMBERLAND MARYLAND

21. Signature of Funeral Service Licensee: Dale L. Merritt

22. Name and Address of Facility: MERRITT-ADAMS FUNERAL HOME P.A. 404 DECATUR STREET CUMBERLAND MARYLAND

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. SELF INFLICTED GUN SHOT WOUND TO THE HEAD — SUDDEN

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ALCOHOL ABUSE SYNDROME

SEIZURE DISORDER

HYPERTENSIVE

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown X

24a. Was an autopsy performed? 1☐Yes 2☒No X

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes X 2☐No

26. Place of Death (Check only one) Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence X 8☐Other (Specify)

27. Manner of Death: 1☐Natural 2☐Accident 3☒Suicide X 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year): JULY 29 1999

28b. Time of Injury: 5 PM M

28c. Injury at Work? 1☐Yes 2☒No X

28d. Describe how injury occurred: SUBJECT SHOT HIMSELF

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): RESIDENCE

28f. Location (Street and Number or Rural Route Number, City or Town, State): 11220 OLD MT PLEASANT ROAD N.E. CUMBERLAND MARYLAND

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner as stated. X

29b. Signature and title of certifier: Paul Snow M

29c. License number: D 09159

29d. Date signed (Month, Day, Year): JULY 29, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR PAUL SNOW 124 WEST 3rd STREET CUMBERLAND, MARYLAND 21502

State Registrar

31. Date filed (Month, Day, Year): JUL 30 1999

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

7

YES

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25584

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WILBERT T. ROBERSON
2. Date of Death (Month, Day, Year): JULY 30 1999
3. Time of Death: 7:50 PM
4a. Facility Name (If not institution, give street and number): Memorial Hospital
4b. City, Town, or Location of Death: CUMBERLAND
4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 219-03-9078
6. Sex: 1 ☐ M 2 ☐ F — X
7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec 6, 1919
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Allegany
10c. City, Town or Location: Cumberland
10d. Inside City Limits: 1 ☐ Yes 2 ☐ No — X
10e. Street and Number: 30 Somerville Avenue
10f. Zip Code: 21502
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? ☒ Yes 2 ☐ No — If Yes, Give Year or Dates: WW II
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☐ No — X — Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): retired
16b. Kind of Business/Industry: Furniture Store

17. Father's Name (First, Middle, Last): Edward Robert Roberson
18. Mother's Name (First, Middle, Meiden Surneme): Susan (Beeman)

19a. Informent's Neme/Reletionship (Type, Print): Virginia L Roberson wife
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 30 Somerville Avenue;Cumberland, MD 21502

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other piece): Sunset Memorial Park
Date: 8/02/
20c. Location - City or Town, Stete: Cumberland, MD

21. Signature of Funeral Service Licensee: Nicholas L. Scarpelli
22. Name and Address of Facility: Scarpelli Funeral Home P.A. Cumberland, Maryland 21502

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart tailure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediete Ceuse (Final diseese or condition resulting in death)
a. SINUS BRADY CARDIA. — 1 HOUR
Due to (or es a consequence of):
b. MASSIVE MYOCARDIAL INFARCTION — 1 HOUR
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
NEUROPATHY, PERIPHERAL

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Wes an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Deeth (Check only one): Hospitel: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Neturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigetion 6 ☐ Could not be determined
28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 ☑ **Certifying Physicien**: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and manner as steted. 2 ☐ **Medical Examiner**: On the besis of exemlnetion and/or Investigetion, in my opinion, deeth occurred at the time, date and pleca, end due to the cause(s) end manner stated.
29b. Signature and title of certifier: M.D.
29c. License number: D23334
29d. Date signed (Month, Day, Year): AUGUST 2nd 1999.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dinesh Shah M.D. 625 Kent Avenue Cumberland MD 21502

State Registrar

31. Date filed (Month, Day, Year): AUG 0 2 1999
32. Registrer's Signeture: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Peges 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health and Mentel Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25585

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Clarence D. Runner

2. Date of Death: Month July Day 30 Year 1999

3. Time of Death: 10:55 a.m.

4a. Facility Name (If not institution, give street and number): Moran Manor Nursing Home

4b. City, Town, or Location of Death: Westernport

4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 705-07-6749

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 99 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 25,1900

9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: WV

10b. County: Mineral

10c. City, Town or Location: Keyser

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 88 South Water Street

10f. Zip Code: 26726

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 2 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Engineer

16b. Kind of Business/Industry: Railroad

17. Father's Name (First, Middle, Last): Charles Runner

18. Mother's Name (First, Middle, Maiden Surname): Sarah Bowman

19a. Informant's Name/Relationship (Type, Print): Ronald M. Runner/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. 1, Box 202-D Keyser, WV 26726

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Potomac Memorial Gardens | Date: Aug. 2 1999

20c. Location - City or Town, State: Keyser, WV

21. Signature of Funeral Service Licensee: ▶ Brian L. Smith

22. Name and Address of Facility: Smith Funeral Home 85 S. Main Street Keyser, WV 26726

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Cardiac Dysrhythmia — 30 minutes

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]

29c. License number: D21244

29d. Date signed (Month, Day, Year): 7/30/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jesus Tan, M.D. Frostburg Plaza Frostburg, MD 21532

State Registrar

31. Date filed (Month, Day, Year): AUG 02 1999

32. Registrar's Signature: [signature] G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25586

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Laura A. Stevenson
2. Date of Death (Month, Day, Year): July 19, 1999
3. Time of Death: 7:25 p.m.
4a. Facility Name (If not institution, give street and number): Devlin Manor Nursing Home
4b. City, Town, or Location of Death: Cumberland
4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 215-42-4364
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 88 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): NOV 28, 1910
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Allegany
10c. City, Town or Location: Cumberland
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 120 W. Second Street
10f. Zip Code: 21502
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Clyde Holler
18. Mother's Name (First, Middle, Maiden Surname): Annie (Stouffer)

19a. Informant's Name/Relationship (Type, Print): Allan R. Stevenson son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14 Brinker Street;Cumberland MD 21502

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Lybarger Lutheran Ceme
Date: 7/22/
20c. Location - City or Town, State: Madley, PA

21. Signature of Funeral Service Licensee: Nicholas J. Scarpelli
22. Name and Address of Facility: Scarpelli Funeral Home P.A. Cumberland, Maryland 21502

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Dementia — 8 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Coronary Artery Disease — 30 yrs
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Deacribe how injury occurred
28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Guy Fiscus MD
29c. License number: D12779
29d. Date signed (Month, Day, Year): July 20, 1999

30. Name and address of person who completed cause of death (Item 29a) (Type, Print): Dr. Guy Fiscus; 500 Memorial Avenue; Cumberland, MD 21502

State Registrar

31. Date filed (Month, Day, Year): JUL 22 1999
32. Registrar's Signature: Geneva G. Spaid

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25587

Certificate of Death

Reg. No.

Betty J. Tyade SS# 220-32-7973

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Betty Daniels Trader

2. Date of Death Month Dey Year: July 31, 1999

3. Time of Death: 0550

4e. Facility Name *(If not institution, give street and number)*: PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 220-32-7973

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 63 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 6/8/36

9. Birthplace *(State or Foreign Country)*: West Va.

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Md.

10b. County: Worcester

10c. City, Town or Location: Snow Hill

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 4837 S. Washington

10f. Zip Code: 21863

10g. Citizen of Whet Country?: U.S.A.

11. Maritel Stetus: 1☐ Never Merried 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Rece - American Indien, Bieck, White, etc. *Specify:* white

15. Decedent's Educetion *(Specify only highest grede completed)*: Elementery/Secondery (0-12): 9 / College (1-4or 5+):

16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: homemaker

16b. Kind of Business/Industry: own home

17. Fether's Neme *(First, Middle, Last)*: William Daniels

18. Mother's Name *(First, Middle, Maiden Surneme)*: Maggie Hall Daniels

19e. Informent's Neme/Reletionship *(Type, Print)*: David J. Trader, Sr.

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 4837 S. Washington St., Snow HIll,Md.21863

20e. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Name of cemetery, crematory or other place)*: Whatcoat Meth.Cem. Dete: 8/3/99

20c. Location - City or Town, State: Snow Hill,Md.

21. Signeture of Funeral Service Licensee: Patricia L. Dennis

22. Name end Address of Feciility: P.O. Box 87 Dennis Funeral Home,Snow Hill,Md.21863

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23e. Part1. Enter the disease, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Deeth

Immediete Ceuse (Finel disease or condition resulting in deeth): a. Dysrythmia — 4 hrs.

Due to (or as e consequence of): b. CHF

Sequentielly list conditions, if eny, ieeding to immediete ceuse. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Lest

Due to (or es e consequence of): c.

Due to (or es e consequence of): d.

Part II. **Other significent conditions** contributing to deeth but not resulting in the underlying ceuse given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes cese referred to medical exeminer? 1☐ Yes 2☒ No

28. Piece of Death *(Check only one)*: Hospitel: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rurel Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of *my* knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of exemineticn end/or investigetion, In *my* opinion, deeth occurred at the time, date end piece, and due to the ceuse(s) end manner stated.

29b. Signeture end title of certifier: [signature]

29c. License number: D34768

29d. Dete signed *(Month, Day, Year)*: 7/31/99

30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print): Dr. Jeffrey Wieland 400 E. Shore Dr. Salisbury Md. 21804

State Registrar

31. Dete filed *(Month, Day, Year)*: AUG 0 2 1999

32. Registrer's Signeture: Geneva G. Sparks

To be completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25588

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: RUTH GRACE TAYLOR
2. Date of Death Month / Day / Year: 08 / 03 / 1999
3. Time of Death: 8:55 PM
4a. Facility Name *(If not institution, give street and number)*: 506 4th Street
4b. City, Town, or Location of Death: Pocomoke City
4c. County of Death: Worcester

Funeral Director

5. Social Security Number: 213-05-2011
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 85 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 1/18/1914
9. Birthplace *(State or Foreign Country)*: Grotons, VA

Usual Residence of Decedent

10a. State: MD
10b. County: Worcester
10c. City, Town or Location: Pocomoke City
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 506 4th Street
10f. Zip Code: 21851
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Sales & Office Worker
16b. Kind of Business/Industry: Retail Sales

17. Father's Name *(First, Middle, Last)*: Samuel Henry Taylor
18. Mother's Name *(First, Middle, Maiden Surname)*: Lillie Florence Bloxom

19a. Informant's Name/Relationship *(Type, Print)*: Winnie Taylor (sister)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 506 4th Street, Pocomoke City, MD 21851

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Downing's Cemetery
Date: 8/6/99
20c. Location - City or Town, State: Oak Hall, Virginia

21. Signature of Funeral Service Licensee: David A. Thompson M01051
22. Name and Address of Facility: Holloway Melson Funeral Home, P.A. 103 Linden Ave., Pocomoke City, MD 21851

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CEREBRAVASCULAR ACCIDENT — MINUTES

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. ARTERIOSCLEROTIC CV DISEASE — YEARS

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 8☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J. G. Santiano MD
29c. License number: D02556
29d. Date signed *(Month, Day, Year)*: 08-05-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. G. Santiano, M.D. - 100 8th Street, Pocomoke City, MD 21851

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 05 1999
32. Registrar's Signature: Geneva G. Sparks

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25589

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MILDRED H. VANCE

2. Date of Death Month / Day / Year: JULY 28 1999

3. Time of Death: 1:20 PM

4a. Facility Name *(If not institution, give street and number)*: GOODWILL MENNONITE HOME

4b. City, Town, or Location of Death: GRANTSVILLE

4c. County of Death: GARRETT

Funeral Director

5. Social Security Number: 214-07-5960

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 89 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: AUG 26, 1909

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ALLEGANY

10c. City, Town or Location: FLINTSTONE

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 12712 MURLEYS BRANCH ROAD NE

10f. Zip Code: 21530

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOUSEWIFE

16b. Kind of Business/Industry: OWN HOME

17. Father's Name *(First, Middle, Last)*: WALTER EICHHORN

18. Mother's Name *(First, Middle, Maiden Surname)*: NELLIE THORPE

19a. Informant's Name/Relationship *(Type, Print)*: DANIEL G. VANCE/SON

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 12712 MURLEYS BRANCH RD NE, FLINTSTONE, MD 21530

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: SUNSET MEMORIAL PARK

Date: JULY 31, 1999

20c. Location - City or Town, State: CUMBERLAND, MD

21. Signature of Funeral Service Licensee: Douglas S. Hafer

22. Name and Address of Facility: HAFER CHAPEL OF THE HILLS MORTUARY 1302 NATIONAL HWY, LAVALE, MD 21502

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Congestive Heart Failure — 4 weeks

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Stroke,
Renal failure
Peripheral vascular disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J E Bertrel MD

29c. License number: D 34079

29d. Date signed *(Month, Day, Year)*: July 28 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): James E Bertrel MD Grantsville MD 21536

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 03 1999

32. Registrar's Signature: D. Spanier

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25590

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: PATRICIA ANN WARRING
2. Date of Death Month Day Year: AUGUST 1, 1999
3. Time of Death: 7:05 PM
4a. Facility Name *(If not institution, give street and number)*: SOUTHERN MARYLAND HOSPITAL CENTER
4b. City, Town, or Location of Death: CLINTON
4c. County of Death: PRINCE GEORGE'S

Funeral Director

5. Social Security Number: 578-58-3902
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 54 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: JUNE 16, 1945
9. Birthplace *(State or Foreign Country)*: WASHINGTON DC

Usual Residence of Decedent

10e. State: MARYLAND
10b. County: CHARLES
10c. City, Town or Location: WALDORF
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 4550 LEONARDTOWN ROAD
10f. Zip Code: 20601
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 0
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name *(First, Middle, Last)*: ROY EARL THOMAS
18. Mother's Name *(First, Middle, Maiden Surname)*: DAISY THERESA BOTTS

19a. Informant's Name/Relationship *(Type, Print)*: VINCENT C. WARRING, SR. - SPOUSE
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4550 LEONARDTOWN ROAD, WALDORF, MARYLAND 20601

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: ST. MARY'S CHURCH CEM.
Date: AUGUST 5, 1999
20c. Location - City or Town, State: BRYANTOWN, MD

21. Signature of Funeral Service licensee: MGB Mark G. Brohawn MARK G. BROHAWN M00053
22. Name and Address of Facility: THE HUNTT FUNERAL HOME, INC. P.O.BOX 156, WALDORF, MARYLAND 20604

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Acute Respiratory failure	18 hrs
Due to (or as a consequence of):	b. septic shock	18 hrs
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. metastatic gastric carcinoma	2½ months
Due to (or as a consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Acute pulmonary embolism; Acute Renal failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Deidra L. Varner MD
29c. License number: D33512
29d. Date signed *(Month, Day, Year)*: 8/2/99

30. Name and address of person who completed cause of death (Item 23a) *(Type, Print)*: DEIDRA L. VARNER, MD / 10274 LAKE ARBOR Way Ste 210 Mitchellville MD 20721

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 04 1999
32. Registrar's Signature: G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: # 4C PER MD, 31 PER V.R. G774 8-12-99 WR. **Certificate of Death**

Reg. No. 99 25591

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BRITTANY WARNE

2. Date of Death: Month 08 Day 07 Year 99

3. Time of Death: 0300

4a. Facility Name (If not institution, give street and number): CARROLL CO GEN. HOSPITAL, 200 MEMORIAL AVE

4b. City, Town, or Location of Death: WESTMINSTER

4c. County of Death: CARROLL WESTMINSTER

Funeral Director

5. Social Security Number: N/A

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours 3 / Min. 30

8. Date of Birth (Month, Day, Year): Aug. 7, 1999

9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: Carroll

10c. City, Town or Location: Lineboro

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 4700 Rill Rd.

10f. Zip Code: 21102

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): N/A; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): N/A

16b. Kind of Business/Industry: N/A

17. Father's Name (First, Middle, Last): Christopher F. Warne

18. Mother's Name (First, Middle, Maiden Surname): Maria L. Rill

19a. Informant's Name/Relationship (Type, Print): Christopher F. Warne/Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4700 Rill Rd., Lineboro, MD 21102

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): New Freedom Cemetery

Date: Aug. 10, 1999

20c. Location - City or Town, State: New Freedom, PA

21. Signature of Funeral Service Licensee: Karen D. Hartenstein

22. Name and Address of Facility: J.J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA 17349

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death: 3½ HRS

Immediate Cause (Final disease or condition resulting in death)

e. EXTREME PREMATURITY

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year): N/A

28b. Time of Injury: M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jerome S. Marare

29c. License number: D21060

29d. Date signed (Month, Day, Year): 8/7/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): JEROME S. MARARE, MD CARROLL CO. GEN. HOSP., 200 MEMORIAL AVE, 21157

State Registrar

31. Date filed (Month, Day, Year): ~~8/6/99~~

32. Registrar's Signature: AUG 12 1999 Geneva G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25592

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John C. Weisenmiller Jr.

2. Date of Death (Month, Day, Year): July 27, 1999

3. Time of Death: 12:35 pm

4a. Facility Name (If not institution, give street and number): Memorial Hospital

4b. City, Town, or Location of Death: Cumberland

4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 219-44-0709

6. Sex: 1 X M 2 F

7. Age (In yrs. last birthday): 50 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug 31, 1948

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: Allegany

10c. City, Town or Location: Cumberland

10d. Inside City Limits: 1 Yes 2 No X

10e. Street and Number: 619 N. Centre Street

10f. Zip Code: 21502

10g. Citizen of What Country? USA

11. Marital Status: 1 Never Married 2 Married 3 Widowed 4 X Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates: 1968-71

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Former Machinist

16b. Kind of Business/Industry: Local Union

17. Father's Name (First, Middle, Last): John C. Weisenmiller, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Dorothy A (Bowman)

19a. Informant's Name/Relationship (Type, Print): Ricky Weisenmiller son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 636 E. Second Street;Cumberland MD 21502

20a. Method of Disposition: 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Rocky Gap Veterans Cem | Date: 7/30/

20c. Location - City or Town, State: Flintstone, MD

21. Signature of Funeral Service Licensee: Nicholas J. Scarpelli

22. Name and Address of Facility: Scarpelli Funeral Home P.A. Cumberland, Maryland 21502

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pulmonary embolus — days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Myocardial infarction

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 X Unknown

24a. Was an autopsy performed? 1 Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 X No

26. Place of Death (Check only one): Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA | Other: 4 Nursing Home 5 Residence 8 Other (Specify)

27. Manner of Death: 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 8 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John [illegible]

29c. License number: D36766

29d. Date signed (Month, Day, Year): July 28, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Vik Poonai, 920 National Highway, LaVale, MD 21502

State Registrar

31. Date filed (Month, Day, Year): JUL 29 1999

32. Registrar's Signature: Lynne B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

JOHN WEISENMILLER 219-44-0709

11

hrs

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25593

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Julia R. Weaver
2. Date of Death Month Day Year: JULY 31, 1999
3. Time of Death: 11:30 P.M.
4a. Facility Name (If not institution, give street and number): Sacred Heart Hospital
4b. City, Town, or Location of Death: Cumberland
4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 204-03-1303
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct 10, 1921
9. Birthplace (State or Foreign Country): PA

Usual Residence of Decedent

10a. State: MD
10b. County: Allegany
10c. City, Town or Location: Frostburg
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 8 Taylor Street
10f. Zip Code: 21532
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Retired
16b. Kind of Business/Industry: Housekeeper

17. Father's Name (First, Middle, Last): Pete Gebhart
18. Mother's Name (First, Middle, Maiden Surname): Louise (Wireman)

19a. Informant's Name/Relationship (Type, Print): Patrick Weaver-son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8 Taylor Street Frostburg MD 21532

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Cumberland Crematory
Date: 08/01
20c. Location - City or Town, State: Cumberland MD

21. Signature of Funeral Service Licensee: John P. Horn
22. Name and Address of Facility: Scarpelli Funeral Home, P.A. Cumberland MD 21502

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Hepatic Failure	3 weeks
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.	Chronic hepatitis	30 years
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.

Stroke, Kidney failure, Hypertension. Depression. esophagitis (Candida). Fracture Right Wrist

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: S L Sandhir MD
29c. License number: D 14464
29d. Date signed (Month, Day, Year): AUGUST 1, ,1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): S.L. Sandhir 48 Tarn Terrace Frostburg, MD 21532

State Registrar

31. Date filed (Month, Day, Year): AUG 02 1999
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10 yrs

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25594

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MYRTLE KATHERINE YOST

2. Date of Death Month / Day / Year: JULY 23, 1999

3. Time of Death: 6:05 AM

4a. Facility Name *(If not institution, give street and number)*: CUMBERLAND NURSING CENTER

4b. City, Town, or Location of Death: CUMBERLAND

4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 212-18-1862

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: NOV. 9, 1913

9. Birthplace *(State or Foreign Country)*: MARYLAND

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: ALLEGANY

10c. City, Town or Location: CUMBERLAND

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 110 KARNS AVENUE

10f. Zip Code: 21502

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: CAFETERIA WORKER

16b. Kind of Business/Industry: ALLEGANY COUNTY BOARD OF EDUCATION

17. Father's Name *(First, Middle, Last)*: JOHN ROMAN

18. Mother's Name *(First, Middle, Maiden Surname)*: MARY CATHERINE GARLICK

19a. Informant's Name/Relationship *(Type, Print)*: HARRY J. YOST / STEPSON

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2429 FAIRHILL DRIVE, SUITLAND, MD 20746

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: HILLCREST BURIAL PARK

Date: 7/26/99

20c. Location - City or Town, State: CUMBERLAND, MD

21. Signature of Funeral Service Licensee: Wendy D. Upchurch

22. Name and Address of Facility: UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD 21502

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Myocardial infarction — Minutes

Due to (or as a consequence of):
b. CAD — Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Emphysema.
Atrial fibrillation

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Peter Helmos

29c. License number: D0Y981

29d. Date signed *(Month, Day, Year)*: July 23. 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): P. HALM-S 302 SCHLEY ST. Cumberland, Md.

State Registrar

31. Date filed *(Month, Day, Year)*: JUL 26 1999

32. Registrar's Signature: B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

10

MS

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25595

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ELAINE BIGELOW

2. Date of Death: Month 08 Day 12 Year 99

3. Time of Death: 6:20pm

4e Facility Name (If not institution, give street and number): UNIVERSITY OF MARYLAND

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death:

Funeral Director

5. Social Security Number: 214-42-3687

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 56 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 1, 1943

9. Birthplace (State or Foreign Country): Washington, D.C.

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yes 2☒ No

10a. Street end Number: 1302 Denbright Road

10f. Zip Code: 21228

10g. Citizen of Whet Country?: United States

11. Maritel Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Wes Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☒ Yes 2☐ No Specify: Panama

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondery (0-12): 12th Grade

College (1-4or 5+): 4+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Registered Nurse

16b. Kind of Business/Industry: Health Ins.

17. Father's Neme (First, Middle, Last): Stanley S. Dougherty

18. Mother's Neme (First, Middle, Meiden Surneme): Vivian M. Stewart

19e. Informent's Neme/Reletionship (Type, Print): Vivian M. Dougherty - Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 1302 Denbright Road; Baltimore, Maryland 21228

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Druid Ridge Cemetery

Dete: 8/16/99

20c. Location - City or Town, Stete: Pikesville, Maryland

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: Loring Byers Funeral Directors, Inc. 8728 Liberty Road; Randallstown, Maryland 21133

Physician /Medical Examiner

23a. Pert I. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximete Intervel Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis

Due to (or es e consequence of):

b. Pneumonia

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last

Due to (or as e consequence of):

c. Multiple Myeloma

Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☒ Yes 2☐ No

24b. Were eutopsy findings aveilable prior to completion of cause of death? 1☐ Yes 2☒ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, dete end piece, end due to the cause(s) end menner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end piece, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: ▶ Joanna M. Saba, MD

29c. License number: P11781

29d. Date signed (Month, Day, Year): 8/12/99

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Joanna M. Saba, 22 S. Greene St., Baltimore, MD 21201

State Registrar

31. Dete filed (Month, Day, Year): AUG 16 1999

32. Registrar's Signeture: [signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

.6 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended #8 perFH G774 8/16/99 EW

Certificate of Death

Reg. No. 99 25596

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Stanislaw Bizon

2. Date of Death (Month, Day, Year): August 11, 1999

3. Time of Death: 4:15 AM

4e Facility Neme (If not institution, give street end number): Church Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-14-8778

6. Sex: 1☐ M 2☑ F

7. Age (In yrs. last birthday): 89 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept. 7, ~~1999~~ 1909

9. Birthplace (State or Foreign Country): Poland

Usual Residence of Decedent

10a. Stete: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimotre

10d. Inside City Limits: 1☑ Yes 2☐ No

10e. Street and Number: 1714 Lancaster Street

10f. Zip Code: 21231

10g. Citizen of What Country?: USA

11. Meritel Status: 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondery (0-12): 4th

College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer

16b. Kind of Business/Industry: Refinary

17. Father's Neme (First, Middle, Last): Jakcub Bizon

18. Mother's Neme (First, Middle, Maiden Surname): Zofia Turek

19e. Informent's Neme/Relationship (Type, Print): Marie Lohinski/Daughter

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6824 Parsons Avenue Baltimore, Maryland 21207

20e. Method of Disposition: 1☑ Buriel 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Name of cemetery, cremetory or other piece): Holy Rosary Cemetery

Date: 8/14/99

20c. Location - City or Town, Stete: Baltimore, Maryland

21. Signeture of Funerel Service Licensee: ▶ Kathleen Weber CFSP

22. Name and Address of Facility: David J. Weber Funeral Homes, P.A. 401 S. Chester St. Baltimore, Maryland 21231

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert failure. List only one ceuse on eech line.

Approximete Intervel Between Onset and Death

Immediete Ceuse (Finel diseese or condition resulting in deeth)

a. acute Myocardial infarction — Due to (or es e consequence of): — 3 days

Sequentielly list conditione, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in deeth) Lest

b. Congestive Heart failen — Due to (or es a consequence of): — Two weeks

c. — Due to (or es e consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospitel: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the cause(s) and menner steted.

29b. Signeture end title of certifier: ▶ R. Sajadi MD

29c. License number: 018951

29d. Dete signed (Month, Day, Year): 8/13/1999

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): REZA SAJADI - 98 North Broadway BALTIMORE MD 21231

State Registrar

31. Dete filed (Month, Day, Year): AUG 16 1999

32. Registrer's Signeture: Linda G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

MILATE

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ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25597

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Metella C. Breschi
2. Date of Death (Month, Day, Year): August 12, 1999
3. Time of Death: 11:50 a.m.

4a. Facility Name (If not institution, give street and number): 3019 Westfield Avenue
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-80-7377
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Apr. 20, 1910
9. Birthplace (State or Foreign Country): Parma, Italy

Usual Residence of Decedent

10a. State: Md.
10b. County: N/A
10c. City, Town or Location: Baltimore City
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3019 Westfield Avenue
10f. Zip Code: 21214
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Eugenio Nencini
18. Mother's Name (First, Middle, Maiden Surname): Angela Villani

19a. Informent's Name/Relationship (Type, Print): Dr. Louis C. Breschi (Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 706 Stone Barn Road Towson, Maryland 21286

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other (Specify): Entombment
20b. Place of Disposition (Name of cemetery, crematory or other place): Dulaney Valley Memorial
Date: 8/14/99
20c. Location - City or Town, State: Timonium Maryland

21. Signature of Funeral Service Licensee: Milton J. Knight Jr
22. Name and Address of Facility: Leonard J. Ruck, Inc. 5305 Harford Rd. Baltimore, Maryland 21214

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. PANCREATIC CARCINOMA — WEEKS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: James Ebeling
29c. License number: D34827
29d. Date signed (Month, Day, Year): 8/13/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JAMES EBELING, MD 7401 OSLER DRIVE SUITE 202 TOWSON MD 21204

State Registrar

31. Date filed (Month, Day, Year): AUG 16 1999
32. Registrar's Signature: Irma G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

REPLACEMENT

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99-25598

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
Herschal Peter Carter	AUGUST 13 1999	00:28

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Union Memorial Hospital	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	If Under 1 Year: Days	If Under 24 Hrs.: Hours	If Under 24 Hrs.: Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-66-5771	1☒ M 2☐ F	41 Yrs.					March 28, 1958	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	Baltimore	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
415 N. Lakewood Avenue	21224	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	-0-	Sales Person	Hess Shoe Stores

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
George Brown	Pauline Carter

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mr. Joseph Myers	415 N. Lakewood Avenue, Baltimore, MD 21244

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Woodlawn Cemetery	8/17/99	Woodlawn, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Stephen M. Jenkins per DVR	Loring Byers Funeral Directors, Inc. 9728 Liberty Road, Randallstown, MD 21133

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. END STAGE RENAL DISEASE	1 week.
Due to (or as a consequence of):	b. Respiratory failure / CHF	4 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c. Acquired Immunodeficiency	4 years.
Due to (or as a consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Mitral valve regurgitation with a regulator.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	D20111	September, 3, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

RAJA E. AYASH UNION MEMORIAL HOSPITAL 201 E. UNIV. PKWY BALT MD 21218

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
SEP 13 1999	▶ [signature] D. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Herschal Carter

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25599

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Ellen Carroll

2. Date of Death: Month August Dey 13 Yeer 1999

3. Time of Death: 9 22 AM

4e. Facility Name (If not institution, give street and number): Mercy Hospital Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

Funeral Director

5. Social Security Number: 220-20-8725

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 72 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Year): June 30, 1927

9. Birthplece (State or Foreign Country): Maryland

Usuel Residenca of Decedent

10e. Stete: Maryland

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 3212 St. Lukes Lane

10f. Zip Code: 21207

10g. Citizen of Whet Country?: United States

11. Merital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed)

Elementery/Secondery (0-12): 12th Grade

College (1-4or 5+): -0-

16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): Case Worker

16b. Kind of Business/Industry: Social Security Administration

17. Fether's Neme (First, Middle, Last): John Minder

18. Mother's Name (First, Middle, Maiden Surneme): Ellen O'Brien

19e. Informant's Neme/Reletionship (Type, Print): James P. Carroll - Son

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 2282 Lake Drive; Pasadena, Maryland 21122

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donation 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other pleca): Woodlawn Cemetery

Dete: 8/17/99

20c. Location - City or Town, Stete: Woodlawn, Maryland

21. Signeture of Funerel Servica Licensee: James T. Herring

22. Neme end Address of Feciility: Loring Byers Funeral Directors, Inc. 8728 Liberty Road; Randallstown, Maryland 21133

Physician /Medical Examiner

23a. Pert I. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert failure. List only one ceuse on eech line.

Approximete Interval Between Onset end Deeth

Immediete Ceuse (Finel diseese or condition resulting in deeth)

a. Cerebrovascular accident — 2 weeks

Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to Immediete cause. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in deeth) Lest

b.

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

Rectal Cancer

Cancer of Colon

23b. Did tobacco use contribute to the ceuse of deeth? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residenca 6☒ Other (Specify) STELLA MARIS at MERCY HOSPICE

27. Menner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and placa, end due to the cause(s) end menner es stated. 2☐ **Medical Examiner:** On the besis of exemination end/or investigation, in my opinion, death occurred et the time, date end placa, end due to the cause(s) end menner stated.

29b. Signeture end title of certifier: D. Riseberg MD

29c. License number: D40854

29d. Date signed (Month, Day, Year): August 13, 1999

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print): DAVID RISEBERG 301 St Paul Pl, BALTIMORE, MD 21202

State Registrar

31. Dete filed (Month, Dey, Yeer): AUG 16 1999

32. Registrer's Signature: James G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25600

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Sherrie R. Carter
2. Date of Death Month: 8 Day: 12 Year: 99
3. Time of Death: 2045
4a. Facility Name (If not institution, give street and number): University of Maryland Medical System
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death:

Funeral Director

5. Social Security Number: 076-54-7735
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 41 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 7 15 58
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 2014 Millenwood Rd.
10f. Zip Code: 21239
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementery/Secondary (0-12): 9th
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): homemaker
16b. Kind of Business/Industry: U.U.D.

17. Father's Name (First, Middle, Last): Robert L. Carter
18. Mother's Name (First, Middle, Maiden Surname): Annie Haddwin

19a. Informant's Name/Relationship (Type, Print): Mary Murray
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2014 Millenwood Rd 21239

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Cedar Hill Cemetery
Date: 8-20-99
20c. Location - City or Town, State: Baltimore

21. Signeture of Funeral Service Licensee: Jeff Miller
22. Name end Address of Facility: Jeff Miller Funeral Home 1639 N. Broadway 21213

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complicetions thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Finel disease or condition resulting in deeth)
a. Meningitis — 2 weeks

Due to (or es a consequence of):
b. Human Immunodeficiency Virus — 20 yrs

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Phyaician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signeture end title of certifier: Gwyneth A. Blattau MD
29c. License number: P13362
29d. Date signed (Month, Day, Year): 8-12-99

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print): Gwyneth A. Blattau 22 S. Greene Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Day, Year): AUG 16 1999
32. Registrars Signeture: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25601

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Roland W. Christopher

2. Date of Death (Month, Day, Year): AUG. 9, 1999

3. Time of Death: 5:25 AM

4a. Facility Name *(If not institution, give street and number)*: Joseph Richey Hospice

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-34-4574

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 60 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: JULY 18, 1939

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Howard

10c. City, Town or Location: Elkridge

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 6498 Montgomery Rd.

10f. Zip Code: 21075

10g. Citizen of Whet Country?: USA

11. Marital Stetus: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indien, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elemantary/Secondary (0-12): 7 | College (1-4or 5+):

16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Assistant Manager

16b. Kind of Business/Industry: Automobile Service Station

17. Fether's Neme *(First, Middle, Last)*: (Unobtainable)

18. Mother's Neme *(First, Middle, Maiden Surname)*: (Unobtainable)

19a. Informent's Neme/Reletionship *(Type, Print)*: Frank Wilkins - friend

19b. Melling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5964 Hunt Club Rd., Elkridge, Md. 21075

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other *(Specify)*

20b. Pleca of Disposition *(Name of cemetery, crematory or other place)*: Baltimore Washington Crem. | Dete: 8/11/99

20c. Location - City or Town, Stete: Laurel, Md.

21. Signeture of Funeral Service Licensee: S. Hallett

22. Neme end Address of Feclity: Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, Md. 21075

Physician /Medical Examiner

23a. Pert I. Enter the disease, or complicetions that caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset end Deeth

Immediete Ceuse (Final disease or condition resulting in death)
e. LUNG CANCER METASTATIC — 7½ mo

Due to (or es e consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in death) Lest
b.

Due to (or es e consequence of):
c.

Due to (or es e consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.: ULCER BLEED

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings available prior to completion of ceuse of deeth? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Plece of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other *(Specify)* HOSPICE

27. Manner of Deeth: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*:

28b. Time of Injury:

28c. Injury at Work? 1 [ ] Yes 2 [X] No

28d. Describe how injury occurred:

28e. Pleca of Injury - At home, farm, street, factory, office building, etc. *(Specify)*:

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*:

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner as stated. 2 [ ] **Medical Examiner:** On the besis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date and place, end due to the cause(s) end menner steted.

29b. Signeture end title of certifier: Michael L. Klein, MD

29c. License number: D-06085

29d. Date signed *(Month, Day, Year)*: 9 August '99

30. Neme end eddress of person who completed causa of death *(Item 23a)* (Type, Print): MICHAEL LEVIN MD - 833 N. EUTAW ST BALTO 21201 JOSEPH RICHEY HOSPICE INC

State Registrar

31. Dete filed *(Month, Day, Yeer)*: AUG 16 1999

32. Registrer's Signature: G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth end Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate hes been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

ROLAND CHRISTOPHER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25602

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Henry Frellsen Page Cassagne

2. Date of Death (Month, Day, Year): Aug 12 1999

3. Time of Death: 3:57AM

4a. Facility Name (If not institution, give street and number): Howard County General Hospital

4b. City, Town, or Location of Death: Columbia

4c. County of Death: Howard

Funeral Director

5. Social Security Number: 439-07-5222

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept. 29, 1920

9. Birthplace (State or Foreign Country): Louisiana

Usual Residence of Decedent

10a. State: MD

10b. County: Howard

10c. City, Town or Location: Columbia

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 5633 Sheerock Court

10f. Zip Code: 21045

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Chief Appraiser

16b. Kind of Business/Industry: HUD

17. Father's Name (First, Middle, Last): Henry Frellsen Page Cassagne, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Alice Braud

19a. Informant's Name/Relationship (Type, Print): Shirley Cassagne (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5633 Sheerock Court, Columbia, MD 21045

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other (Specify) Entombment

20b. Place of Disposition (Name of cemetery, crematory or other place): Crestlawn Memorial Park

Date: 8/17/99

20c. Location - City or Town, State: Marriottsville, MD

21. Signature of Funeral Service Licensee: ▶ Robert Gregory Burhans

22. Name and Address of Facility: Witzke Funeral Homes, Inc. 5555 Twin Knolls Road, Columbia, MD 21045

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Hypopharyngeal and/or Gastrointestinal Hemorrhage — hours

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Carcinoma of the Tongue - metastatic — years.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

diabetes mellitus Type II

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Patrice A. Toye MD Deputy ME

29c. License number: D31473

29d. Date signed (Month, Day, Year): Aug 13, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PATRICE A. TOYE, MD 4565 Hemlock Cone Way Ellicott City MD 21042

State Registrar

31. Date filed (Month, Day, Year): AUG 16 1999

32. Registrar's Signature: Georgia D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director; page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10/1
WR

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25603

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: HARRISON COLLINS
2. Date of Death Month Day Year: 08-11-99
3. Time of Death: 11:50 PM
4a. Facility Name *(If not institution, give street and number)*: 1628 DELANO CT
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-24-9583
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 71 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 01-7-28
9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10a. Street and Number: 1628 DELANO CT.
10f. Zip Code: 21217
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: BAKER
16b. Kind of Business/Industry: FOOD

17. Father's Name *(First, Middle, Last)*: BUSTER COLLINS
18. Mother's Name *(First, Middle, Maiden Surname)*: IRENE JONES

19a. Informant's Name/Relationship *(Type, Print)*: KEVIN COOK/SON
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3615 GELSTON DR. BALTO., MD. 21229

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: KING MEMORIAL PK — Date: 8/16/99
20c. Location - City or Town, State: BALTIMORE, MD.

21. Signature of Funeral Service Licensee: James A. Morton
22. Name and Address of Facility: JAMES A. MORTON & SONS FUNERAL HOMES, INC. 1701 LAURENS ST. BALTIMORE, MD. 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	heart attack	minutes
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.	cardiomyopathy / hypertrophy	years
Due to (or as a consequence of):		
c.	hypertension	years
Due to (or as a consequence of):		
d.	alcohol use	years

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: gastritis, hepatitis

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: B. Klein MD
29c. License number: D46289
29d. Date signed *(Month, Day, Year)*: 8/13/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Belinda Y. Chen, MD 1300 N. Fulton Avenue Baltimore, MD 21217

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 16 1999
32. Registrar's Signature: for B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

WRC
99-4521-510
ROBERT ROSCOE
CORNISH

AMEND ITEM# 1, 23 PART I, 27, 28A-F PER MEO G774 8-18-99 WR

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25604

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ralph Roscoe Cornish
2. Date of Death (Month, Day, Year): AUG. 01, 1999
3. Time of Death: 8:25 PM.
4e. Facility Name (If not institution, give street and number): SHOCK TRAUMA
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-35-6243
6. Sex: 1☑ M 2☐ F
7. Age (In yrs. last birthday): 37 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 20, 1962
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Lansdowne
10d. Inside City Limits: 1☐ Yes 2☑ No
10e. Street and Number: 2936 Lakebrook Circle Apt. 104
10f. Zip Code: 21227
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☑ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Taxi Driver
16b. Kind of Business/Industry: Transportation

17. Father's Name (First, Middle, Last): Ralph Cornish
18. Mother's Name (First, Middle, Maiden Surname): Geraldine Bond

19a. Informant's Name/Relationship (Type, Print): Shavonne Cornish
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2936 Lakebrook Circle Apt. 104 Balto., Md. 21227

20e. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Zion Cemetery
Date: 8-11-99
20c. Location - City or Town, State: Lansdowne, MD.

21. Signature of Funeral Service Licensee: Gary P. March
22. Name and Address of Facility: Gary P. March Funeral Home P.A. 870 Fred Hilton Pass Balto., MD. 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. CUT TO RIGHT BRACHIAL ARTERY AND COCAINE INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☑ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? XX Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion XX 6☐ Could not be determined
28a. Date of Injury (Month, Day Year): AUG 1, 1999
28b. Time of Injury: 7:26 P M
28c. Injury at Work? 1☐ Yes 2☑ No
28d. Describe how injury occurred: PUT ARM THROUGH FRONT GLASS DOOR
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): RESIDENCE
28f. Location (Street and Number or Rural Route Number, City or Town, State): 26 BRISTOL AVE. BALTIMORE, MD.

29a. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mennar as stated. XX Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted.
29b. Signature and title of certifier: Wayne Brettell
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): AUG. 02, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): [illegible] A. KOLER M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): AUG 16 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25605

Certificate of Death Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Perlina Dove
2. Date of Death Month Day Year: Aug. 12 1999
3. Time of Death: 9:20AM
4a. Facility Name (If not institution, give street and number): Good Samaritan Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: NA

Funeral Director

5. Social Security Number: 240-12-5088
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 95 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 06-28-04
9. Birthplace (State or Foreign Country): NC

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: ☒Yes 2☐ No
10e. Street and Number: 1531 Sheffield Road
10f. Zip Code: 21218
10g. Citizen of What Country?: USA

11. Meritel Status: 1☐ Never Married 2☐ Merried 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Bleck, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 5th Grade; College (1-4or 5+): NA
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: Gibbs Company

17. Father's Name (First, Middle, Last): Haywood Springfield
18. Mother's Name (First, Middle, Maiden Surneme): Sarah Armstrong

19a. Informent's Name/Relationship (Type, Print): Mary L. Artis
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 1531 Sheffield Road Baltimore, MD. 21218

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Zion Cemetery
Date: 08-17-99
20c. Location - City or Town, State: Lansdowne, MD

21. Signature of Funerel Service Licensee: [signature]
22. Name and Address of Facility: Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heart faiture. List only one cause on each line.

		Approximete Interval Between Onset and Death
Immediate Cause (Finat disease or condition resulting in death) a.	Sepsis	1 week
Due to (or es e consequence of): b.	pneumonia	1 week.
Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or tnjury thet initieted events resulting tn death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other alginificant conditiona** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco uae contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an eutopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings eveilable prior to completion of ceuse of death? 1☐ Yes 2☑ No

25. Was cese referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Restdence 6☐ Other (Specify)

27. Menner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homictde 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how tnjury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Phyalcian**: To the best of my knowledge, death occurred et the time, date and piece, end due to the ceuse(s) and manner as stated. 2☐ **Medicel Examiner**: On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the cause(s) end manner stated.

29b. Signature and title of certifier: [signature] Attending Physician
29c. License number: D53642
29d. Date signed (Month, Day, Year): Aug. 12 1999

30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print): DIAO MING ZHOU 3007 E. Northern Parkway Baltimore

State Registrar

31. Date filed (Month, Day, Year): AUG 16 1999
32. Registrar's Signature: [signature] D. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours efter death with tha Meryland Department of Health end Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours efter death.
To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

DHMH 16 Rev 6/95

99-4681-033
CJ
Jessie Derricote

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25606

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JESSIE L. DERRICOTT
2. Date of Death Month: August Day: 12 Year: 1999
3. Time of Death: 03:30 PM.
4a. Facility Name (If not institution, give street and number): Fort Washington Medical Center
4b. City, Town, or Location of Death: Fort Washington
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 226-20-5238
6. Sex: 1☑M 2☐F
7. Age (In yrs. last birthday): 71 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 10-25-1926
9. Birthplace (State or Foreign Country): CAROLINE, VA

Usual Residence of Decedent

10a. State: MD
10b. County: Prince George
10c. City, Town or Location: OXON, HILL
10d. Inside City Limits: 1☐Yes 2☑No
10e. Street and Number: 6482 Brock Rd.
10f. Zip Code: 20744
10g. Citizen of What Country? USA

11. Marital Status: 1☐Never Married 2☑Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☑No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☑No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): TRUCK DRIVER
16b. Kind of Business/Industry: TRANSPORTATION

17. Father's Name (First, Middle, Last): SYLVESTER DERRICOTT
18. Mother's Name (First, Middle, Maiden Surname): MARIE SARGENT

19a. Informant's Name/Relationship (Type, Print): WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6482 Brock Rd. OXON HILL, MD

20a. Method of Disposition: 1☑Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): CAROLINE CITY FAMILY CEMETERY VA
Date: 8-19-99
20c. Location - City or Town, State: CAROLINE, VA

21. Signature of Funeral Service Licensee: Michael Ziglier
22. Name and Address of Facility: HOWELL FUNERAL HOME 4600 LIBERTY HEIGHTS AVE.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Hypertensive and atherosclerotic
Due to (or as a consequence of):
b. Cardiovascular Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☑Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☑Yes 2☐No
24b. Were autopsy findings available prior to completion of cause of death? 1☑Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No
26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)
27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J Pestaner, M.D.
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): August 13, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): AUG 16 1999
32. Registrar's Signature: G. Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25607

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Dolores Ann Delegge
2. Date of Death (Month, Day, Year): August 14, 1999
3. Time of Death: 2:00 AM
4a. Facility Name (If not institution, give street and number): Cromwell Nursing Center GEC
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 214-14-9837
6. Sex: 1☐ M 2☐ F XX
7. Age (In yrs. last birthday): 76 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 28, 1923
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Perry Hall
10d. Inside City Limits: 1☐ Yes 2☐ No XX
10e. Street and Number: 3805 Perryhurst Place
10f. Zip Code: 21236
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married X 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No X Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Office Manager
16b. Kind of Business/Industry: Teamsters

17. Father's Name (First, Middle, Last): Walter Edward Smith
18. Mother's Name (First, Middle, Meiden Surname): Grace Ethel Warner

19a. Informent's Name/Relationship (Type, Print): Jo Anne Magee
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3805 Perry Hurst Pl. Perry Hall, Maryland 21236

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Holy Redeemer Cemetery
Date: 8/17/99
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Marion J. Dippelt
22. Name and Address of Facility: Dippel Funeral Home Inc. 7110 Belair road Balto. MD. 21206

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Failure to Thrive
Due to (or as a consequence of): Dementia
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Ziad Mirza MD
29c. License number: D41901
29d. Date signed (Month, Day, Year): 8-16-99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ziad Mirza, 3007E Northern Parkway, Baltimore, MD 21214

State Registrar

31. Date filed (Month, Day, Year): AUG 16 1999
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25608

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARGARET ELIZABETH DIXON

2. Date of Death Month / Day / Year: AUGUST 12, 1999

3. Time of Death: 4:15 AM

4a. Facility Name *(If not institution, giva street end number)*: Saint Joseph Medical Center

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 578 48 5004

6. Sax: 1☐ M 2☒ F

7. Aga *(In yrs. last birthday)*: 65 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Day, Year)*: Oct. 12, 1933

9. Birthplaca *(State or Foreign Country)*: Washington DC

Usual Rasidance of Dacedent

10a. Stata: Maryland

10b. County: Harford

10c. City, Town or Location: Forest Hill

10d. Insida City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 314 Pond View Ct.

10f. Zip Code: 21050

10g. Citizan of What Country?: United States

11. Marital Status: 1☐ Navar Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Specify:*

14. Race - Amarican Indian, Black, Whita, atc. *Specify:* White

15. Decedent's Education *(Specify only highast grada complatad)*: Elementary/Secondary (0-12): 12; Collaga (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Giva kind of work done during most of working lifa. DO NOT use retired)*: Clerk

16b. Kind of Businass/Industry: Customer Service

17. Fathar's Nama *(First, Middla, Last)*: Frederick Dixon

18. Mother's Neme *(First, Middla, Maiden Surname)*: Louise Killius

19a. Informant's Name/Relationship *(Type, Print)*: Rebecca Richardson / Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Coda)*: 314 Pond View Ct., Forest Hill, MD 21050

20a. Mathod of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Placa of Disposition *(Nama of cematary, cramatory or othar place)*: Green Mount Crematory

Data: 8/13/99

20c. Location - City or Town, Stata: Baltimore, MD

21. Signature of Funeral Service Licensee: Stephen D. Lohrmann

22. Nama and Address of Facility: CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr., Baltimore, MD 21286

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that causad tha daath. Do not anter tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only one causa on aach lina.

Approximate Intarval Batwaan Onsat and Death

Immediata Causa (Final disaasa or condition rasulting in death)

a. HEPATIC ENCEPHALOPATHY

Due to (or as a consequanca of):

Sequantially list conditions, if any, leading to immadiate causa. Enter Undarlying Ceuse (Diseasa or injury that initiated events resulting in death) Last

b. CIRRHOSIS

Due to (or as a consequence of):

c.

Dua to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha undarlying cause given in Part I.

ACUTE RENAL FAILURE

CORONARY ARTERY DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Were autopsy findings aveileble prior to completion of cause of death? 1☐ Yas 2☒ No

25. Wes casa raferred to medical examinar? 1☐ Yas 2☒ No

26. Place of Deeth *(Chack only ona)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Othar: 4☐ Nursing Homa 5☐ Rasidence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending Investigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Yaar)*

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28a. Place of Injury - At homa, farm, street, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowladge, deeth occurred at tha tima, data and place, and due to the ceuse(s) and manner as steted. 2☐ **Medical Examiner**: On the basis of axamination and/or invastigation, in my opinion, death occurred at the tima, data and place, and due to tha cause(s) and manner steted.

29b. Signatura and title of certifier: [signature]

29c. License number: D 30263

29d. Date signed *(Month, Day, Year)*: 8-12-99

30. Nama and address of person who completed causa of death (Item 23e) (Type, Print): FRANCIS KHOO, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204

State Registrar

31. Data filed *(Month, Day, Year)*: AUG 16 1999

32. Registrar's Signatura: B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that tha death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

AAS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25609

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Frank Edward Emery Sr.
2. Data of Death Month Day Year: August 12 1999
3. Time of Death: 1405
4a. Facility Name (If not institution, give street and number): Fallston General Hospital
4b. City, Town, or Location of Death: Fallston
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 212-05-8902
6. Sex: 1 X M 2 F
7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): June 23 1913
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Hartland Village Essex
10d. Inside City Limits: 1 Yas 2 X No
10e. Street and Number: 1104 B Sandystone Road
10f. Zip Code: 21221
10g. Citizen of What Country?: U.S. of America

11. Marital Status: 1 Never Married 2 X Married 3 Widowed 4 Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuben, Mexican, Puarto Rican, atc.) 1 Yes 2 X No Specify:
14. Race - American Indian, Black, Whita, atc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+): NA
16a. Decedent's Usuat Occupation (Give kind of work done during most of working life. DO NOT use retired): Forman Assembly Line
16b. Kind of Business/Industry: Esskay Meats

17. Father's Name (First, Middle, Last): Edward Emery
18. Mother's Name (First, Middle, Meiden Surname): Francis Fuch

19a. Informant's Name/Relationship (Type, Print): Patricia Spencer (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 615 D Cranbrook Rd. Cockeysville, Md. 21030

20a. Method of Disposition: 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Oak Lawn | August 16
20c. Location - City or Town, Stata: East Point, Md.

21. Signature of Funeral Service Licensee: ▶ Mark A. Dąbrowski
22. Nama and Address of Facility: W. Dabrowski-Chojnacki F.H.'s P.A. 1005 Dundalk Ave. Balto., Md. 21224

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not entar the moda of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. | Approximata Interval Between Onsat and Death

Immediata Cause (Final disease or condition resulting in death): a. Acute Bilateral Subdural Hematoma — 8 days
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Chronic Renal Failure; Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death? 1 Yas 2 X No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yas 2 X No
24b. Were autopsy findings available prior to completion of causa of death? 1 Yas 2 X No

25. Was casa refarred to medicat examiner? 1 Yes 2 X No
26. Placa of Death (Check only one): Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA; Other: 4 Nursing Homa 5 Residence 6 Other (Specify)

27. Manner of Death: 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Tima of Injury M
28c. Injury at Work? 1 Yas 2 No
28d. Describe how injury occurred
28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and manner es stated. 2 **Medical Examiner:** On the basis of axamination and/or invastigation, in my opinion, daath occurred at the tima, date and placa, and due to tha cause(s) and manner stated.

29b. Signature and titla of certifier: ▶ MD
29c. License number: D19583
29d. Data signed (Month, Day, Year): August 13, 1999

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print): MANUEL M. LAZATIN MD 8 Law Street, Aberdeen, Maryland 21001

State Registrar

31. Date filed (Month, Day, Year): AUG 16 1999
32. Registrar's Signatura: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Emery, Frank

A45

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25610

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: SYRITA FINLEY

2. Date of Death — Month: August Day: 09 Year: 1999

3. Time of Death: 7:57AM

4a. Facility Name *(If not institution, give street and number)*: Harbor Hospital Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

Funeral Director

5. Social Security Number: 218-60-2666

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 44 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Date of Birth *(Month, Day, Year)*: 11-1-54

9. Birthplace *(State or Foreign Country)*: SC

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2564 Aisquith Street

10f. Zip Code: 21218

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, spacify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education *(Specify only highest grade completed)*

Elementary/Secondary (0-12): 12thGrade

College (1-4or 5+): NA

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Laborer

16b. Kind of Business/Industry: VA Hospital

17. Father's Name *(First, Middle, Last)*: Johnnie Mitchell

18. Mother's Name *(First, Middle, Maiden Surname)*: Maggie Fields

19a. Informant's Name/Relationship *(Type, Print)*: Johnnie Wheeler

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2564 Aisquith Street Baltimore, MD 21218

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Garrison Forest VA Cem.

Date: 08-17-99

20c. Location - City or Town, State: Owings Mills, MD

21. Signature of Funeral Service Licensee: ▶ Willie Edmond

22. Name and Address of Facility: Baltimore, Maryland 21202

WM.C. March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Advanced HIV Infection with multiple organ failure — 10 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic Renal failure

chronic pancreatitis

HIV Induced Leukoencephalopathy, Low CD4 count

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☑ Yes 2☐ No

26. Place of Death *(Check only one)*

Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Mohamad Bakleh

29c. License number: AS2441614 A33

29d. Date signed *(Month, Day, Year)*: August, 09, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Mohanad Bakleh 3001 South Hanover St, Baltimore, MD 21225

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 16 1999

32. Registrar's Signature: Bonnie G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25611

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RUDOLPH DELANO GROSS

2. Date of Death: Month AUG Day 14 Year 1999

3. Time of Death: 11:44am

4a. Facility Name (If not institution, give street and number): NORTHWEST HOSPITAL CENTER

4b. City, Town, or Location of Death: RANDALLSTOWN

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 212-30-9272

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 66 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 5-23-33

9. Birthplace (State or Foreign Country): ANNAPOLIS, MD

Usual Residence of Decedent

10a. State: MD

10b. County: BALTIMORE

10c. City, Town or Location: BALTIMORE, COUNTY

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 3940 LUMO CIRCLE

10f. Zip Code: 21133

10g. Citizen of What Country?: U.S.A.

11. Meritel Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12 | College (1-4or 5+): 4

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): JUVENILE SERVICES

16b. Kind of Business/Industry: MD STATE

17. Father's Neme (First, Middle, Last): PRESTON GROSS

18. Mother's Name (First, Middle, Maiden Surname): JOSEPHINE GROSS

19a. Informant's Neme/Relationship (Type, Print): ESSIE GROSS, WIFE

19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3940 LUMO CIRCLE, RANDALLSTOWN, MD 21133

20a. Method of Disposition: 1 [X] Buriel 2 [ ] Cremetion 3 [ ] Removel from Stete 4 [ ] Donetion 5 [ ] Other (Specify)

20b. Piece of Disposition (Name of cemetery, cremetory or other piece): ARBUTUS CEMETERY

Date: 8-20-99

20c. Location - City or Town, Stete: ARBUTUS, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name end Address of Facility: HOWELL FUNERAL HOME 4600 LIBERTY HGHTS AVE, BALTO. MD 21207

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert failure. List only one cause on eech line.

Approximete Interval Between Onset and Death

Immediete Cause (Finel diseese or condition resulting in deeth)

a. acute myocardiac/infarction — 2 hours

Due to (or as e consequence of):

b. coronary artery disease — years

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

mitral valuvlar disease

ventricular tachylardia

congestive heart failure

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Wes an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Menner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Dete of Injury (Month, Day Yeer)

28b. Time of Injury M

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steted.

29b. Signature and title of certifier: [signature] MD

29c. License number: D47587

29d. Date signed (Month, Day, Year): Aug 14, 1999

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print): ROBERTS FUNERAL HOME 3401 OLD COURT RD. RANDALLSTOWN MD 21133

State Registrar

31. Dete filed (Month, Day, Year): AUG 16 1999

32. Registrer's Signeture: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

99-4713-510
jhm
ALLEN
GREEN

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25612

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Allen Edward Green Jr.
2. Date of Death (Month, Day, Year): AUGUST 15, 1999
3. Time of Death: 00:59 AM
4a. Facility Name (If not institution, give street and number): HARBOR HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death:

Funeral Director

5. Social Security Number: 214-40-8084
6. Sex: 1 ☑ M 2 ☐ F
7. Age (In yrs. last birthday): 57 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 6 24 42
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☑ Yes 2 ☐ No
10e. Street and Number: 2812 Potee Street
10f. Zip Code: 21225
10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11th | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Crain Operator
16b. Kind of Business/Industry: Beth Steel

17. Father's Name (First, Middle, Last): ALLEN Green
18. Mother's Name (First, Middle, Maiden Surname): Annie Laster

19a. Informant's Name/Relationship (Type, Print): Alva Green - Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2812 Potee Street Balto., Md. 21225

20a. Method of Disposition: 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory | Date: 8-17-99
20c. Location - City or Town, State: Balto. Md.

21. Signature of Funeral Service Licensee: Jeff Miller
22. Name and Address of Facility: Jeff Miller P.A. Funeral Home & Services 1639 N. Broadway Balto., Md. 21213

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or brain failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. Hypertensive atherosclerotic cardiovascular disease

Due to (or as a consequence of):
b.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier
29c. License number: OCME
29d. Date signed (Month, Day, Year): AUGUST 15, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David R Fowler 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): AUG 16 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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Medical Certification: To Be Completed by Physician/Medical Examiner

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25613

AMEND ITEMS: #8 PER F.H. G774 8-24-99 WR.

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): MARSHALL GARDINER

2. Dete of Death Month: Aug Day: 12 Yeer: 99

3. Time of Death: 1057

4e. Feciity Name (If not institution, give street end number): North Arundel Hospital

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: AA

Funeral Director

5. Social Security Number: 510-09-9910

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 86 Yrs.

If Under 1 Yeer: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Dey, Yeer): 9-27-1912 ~~September 12, 1912~~

9. Birthpiece (Stete or Foreign Country): Kansas

Usual Residence of Decedent

10e. Stete: Kansas

10b. County: Leavenworth

10c. City, Town or Location: Leavenworth

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 1131 Olive Street

10f. Zip Code: 66048

10g. Citizen of Whet Country?: USA

11. Meritel Status: 1☐ Never Merried 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yeer or Dates: W.W.II

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Rece - American Indian, Bleck, White, etc. Specify: white

15. Decedent's Education (Specify only highest grede completed): Elementary/Secondary (0-12): / College (1-4or 5+): 4

16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Financial Consultant

16b. Kind of Business/Industry: Finance

17. Fether's Neme (First, Middle, Last): Joseph Gardiner

18. Mother's Neme (First, Middle, Meiden Surneme): Alice Gephart

19e. Informent's Neme/Reletionship (Type, Print): J'Noel Gardiner

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 1480 N.W. Brinkmeyers Road, Parkville, MO 64152

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☒ Removel from Stete 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other pleca): Wise Cemetery

Dete: 8/18/99

20c. Location - City or Town, Stete: Winchester, KS

21. Signeture of Funeral Service Licensee: Steven H. Williams, MO0986

22. Neme end Address of Feciity: Gary L. Kaufman Funeral Home @ Meadowridge Memorial Park, Inc 7250 Washington Blvd., Elkridge, MD 21075

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications thet ceused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert failure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Deeth

Immediate Ceuse (Finel disease or condition resulting in death): e. Acute Cardiac Arrhythmia — Minutes

Due to (or es e consequenca of):

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Diseese or Injury thet Initieted events resulting in deeth) Lest:

b. Arteriosclerotic Heart Disease

Due to (or es e consequence of):

c.

Due to (or es e consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yee 2☐ No 3☐ Probebly 4☒ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Deeth (Check only one): Hospitel: 1☐ Inpetient 2☒ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, fectory, offica building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2☒ **Medical Examiner:** On the besis of exemination end/or investigetion, in my opinion, deeth occurred et the time, dete end place, end due to the cause(s) end manner stated.

29b. Signeture end title of certifier: William P. Jones Deputy MD

29c. License number: D 06054

29d. Dete signed (Month, Day, Year): 8/12/99

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): William P. Jones, MD 695 America 21035

State Registrar

31. Dete filed (Month, Day, Year): AUG 16 1999

32. Registrer's Signeture: D. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Peges 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health end Mentel Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the deeth certificate be executed within 24 hours efter death.
To the Funeral Director: After this certificate hes been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

AA 304

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25614

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ARTHUR F. GENSLER

2. Dete of Deeth — Month: AUGUST Dey: 14 Yeer: 1999

3. Time of Deeth: 7:11 pm

4e. Fecility Neme (If not institution, give street end number): VETERANS ADMINISTRATION HOSPITAL

4b. City, Town, or Location of Deeth: BALTIMORE

4c. County of Deeth: BALTIMORE

Funeral Director

5. Sociel Security Number: 216-16-0736

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthdey): 75 Yrs. — If Under 1 Yeer: Months / Deys — If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Dey, Yeer): 6/1/24

9. Birthplece (Stete or Foreign Country): MARYLAND

Usuel Residence of Decedent

10a. State: MD

10b. County: BALTIMORE

10c. City, Town or Location: WOODLAWN

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 5420 MONTBEL AVENUE

10f. Zip Code: 21207

10g. Citizen of Whet Country?: USA

11. Meritel Stetus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No — If Yes, Give Yeer or Detes: WW II

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.): 1☐ Yes 2☒ No Specify:

14. Rece - Americen Indien, Bleck, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed) — Elementery/Secondary (0-12): 10th GRADE — College (1-4or 5+):

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): OPTICAL LENS GRINDE

16b. Kind of Business/Industry: EYE GLASS

17. Fether's Neme (First, Middle, Last): FRANK W. GENSLER, SR.

18. Mother's Neme (First, Middle, Meiden Sumeme): MARGARET HUMMEL

19e. Informent's Neme/Reletionship (Type, Print): HELEN I. GENSLER WIFE

19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 5420 MONTBEL AVENUE BALTIMORE, MD 21207

20e. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): WOODLAWN CEMETERY

Dete: 8/18/99

20c. Locetion - City or Town, Stete: WOODLAWN, MD

21. Signeture of Funerel Service Licensee

22. Neme end Address of Fecility: THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286

Physician /Medical Examiner

23a. Pert I. Enter the diseese, or complicetions that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert feilure. List only one cause on eech line.

Approximete Intervel Between Onset end Death

Immediete Ceuse (Finel diseese or condition resulting in deeth): e. CARCINOID METASTATIC — 4 months

Due to (or as e consequence of):

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Diseese or Injury thet initieted events resulting in deeth) Lest:

b. RESPIRATORY FAILURE

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Pert II. **Other significent conditions** contributing to deeth but not resulting in the underlying cause given in Pert I.

23b. Did tobecco use contribute to the cause of deeth? 1☐ Yes 2☐ No 3☐ Probebly 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Wes case referred to medicel exeminer? 1☐ Yes 2☒ No

26. Plece of Deeth (Check only one) — Hospitel: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Locetion (Street end Number or Rurel Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner es steted. 2☐ **Medical Examiner**: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, dete end plece, end due to the cause(s) end menner steted.

29b. Signeture end title of certifier: MD

29c. License number: 1310686

29d. Dete signed (Month, Dey, Yeer): August 14, 1999

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print): CHUKWUMA OBI ONYEWU BT VAMC 10 NORTH GREENE ST. 21201

State Registrar

31. Dete filed (Month, Dey, Yeer): AUG 16 1999

32. Registrer's Signeture: G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

AH 10/1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25615

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Dey	Year	3. Time of Death
Pierce	Barany	Hamilton	August	11,	1999	4:25 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
6703 Carroll Highlands Road	Sykesville	Carroll

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-32-2181	1☐ M 2☒ F	64 Yrs.					06-14-1935	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Carroll	Sykesville	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6703 Carroll Highlands Road	21784	U.S.A.

11. Meritel Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Yeer or Dates:	1☐ Yes 2☒ No *Specify:*	*Specify:* White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondery (0-12)	College (1-4or 5+)		
12 Years	4 Years	Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Neme (First, Middle, Maiden Surname)
Charles G. Barany	Pierce Billhart

19a. Informent's Neme/Reletionship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Allan P. Hamilton (Husband)	6703 Carroll Highlands Rd. Sykesville, MD 21784

20a. Method of Disposition	20b. Piece of Disposition (Name of cemetery, crematory or other place)	Dete	20c. Location - City or Town, Stete
1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)	Lake View Memorial Park	8-14	Sykesville, Maryland

21. Signature of Funeral Service Licensee	22. Name end Address of Facility
▶ J. Wayne Osterling	Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

		Approximate Interval Between Onset and Deeth
Immediete Ceuse (Finat diseese or condition resulting in deeth)	a. ENDOMETRIAL CARCINOMA	2 MONTHS.
	Due to (or as e consequence of):	
Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or es e consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medicat exeminer?	26. Place of Deeth (Check only one)	
1☐ Yes 2☒ No	Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Menner of Death	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the ceuse(s) end manner steted.

29b. Signeture and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Chitra Gopal / DR. CHITRA RAJAGOPAL M.D.	MARYLAND D 1-2452	AUGUST 12, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. CHITRA RAJAGOPAL, M.D.
18111, PRINCE PHILIP DRIVE #327, OLNEY MD 20832

State Registrar

31. Date filed (Month, Day, Year)	32. Registrer's Signature
AUG 16 1999	Geneva G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ORIGINAL

99-4571-510
DDG
DANIEL S. HORNEY

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25616

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DANIEL SANDERSON HORNEY
2. Date of Death (Month, Day, Year): AUGUST 5, 1999
3. Time of Death: 0705 AM
4a. Facility Name (If not institution, give street and number): HARBOR HOSPITAL CENTER
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death:

Funeral Director

5. Social Security Number: 220 68 7290
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 53 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 21, 1945
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Glen Burnie
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 301 Juneberry Way, Apt. 3A
10f. Zip Code: 21061
10g. Citizen of What Country?: United States

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Not Applicable
16b. Kind of Business/Industry:

17. Father's Name (First, Middle, Last): James Horney
18. Mother's Name (First, Middle, Maiden Surname): Lydia Sanderson Griscom

19a. Informant's Name/Relationship (Type, Print): Chloe Griffis / Sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 413 Duvall Lane, Annapolis, MD 21403

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Green Mount Crematory | Date: 8/14/99
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Stephen D. Lohrmann
22. Name and Address of Facility: CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr., Baltimore, MD 21286

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death):
a. CARDIAC TAMPONADE DUE TO RUPTURED MYOCARDIAL
Due to (or as a consequence of):
b. INFARCT
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [✓] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [✓] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Wayne Buckhalt
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): AUGUST 5, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): H Stephen D. Lohrmann 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): AUG 16 1999
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

AA5

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25617

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: DORA HELEN HAYDEN
2. Data of Death Month / Day / Yaar: August 11 1999
3. Time of Death: 6:55 PM
4a. Facility Nema *(If not institution, giva street and number)*: COLLEGE MANOR, INC
4b. City, Town, or Location of Deeth: LUTHERVILLE
4c. County of Deeth: 13 BALTIMORE

Funeral Director

5. Social Security Number: 216-05-3793
6. Sax: 1☐ M 2☒ F
7. Aga *(In yrs. last birthday)*: 86 Yrs.
If Under 1 Yeer: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Yeer)*: Oct. 26 1912
9. Birthplace *(Stata or Foraign Country)*: Md.

Usual Residence of Decedant

10e. State: Md
10b. County: BALTIMORE
10c. City, Town or Location: ESSEX
10d. Inside City Limits: 1☐ Yas 2☒ No
10e. Street and Number: 1809 HILTON AVENUE
10f. Zip Coda: 21221
10g. Citizan of What Country?: USA

11. Maritel Stetus: 1☐ Navar Married 2☐ Married 3☒ Widowad 4☐ Divorced
12. Wes Dacedent Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Give Yeer or Datas:
13. Wes Decedant of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puarto Ricen, atc.) 1☐ Yas 2☒ No *Specify:*
14. Race - Amarican Indian, Black, Whita, atc. *Specify:* WHITE
15. Dacedent's Education *(Specify only highast grade complated)*: Elamantary/Secondary (0-12): 12th; Collega (1-4or 5+): NA
16a. Decedant's Usuel Occupation *(Giva kind of work done during most of working lifa. DO NOT use retired)*: HOMEMAKER
16b. Kind of Businass/Industry: HOME
17. Fathar's Nama *(First, Middle, Last)*: JOHN W. TESAR
18. Mothar's Nama *(First, Middle, Maidan Sumama)*: DORA HASSELBARTH
19a. Informant's Name/Ralationship *(Type, Print)*: DAWN W. EWELL
19b. Mailing Addrass *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 2820 O'DONNELL ST. BALTO. Md 21224
20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*
20b. Place of Disposition *(Nama of cemetary, cramatory or othar place)*: SWARTZ CEMENTERY
Data: 8/14/99
20c. Location - City or Town, Stata: BALTIMORE, Md.
21. Signature of Funarel Service Licensaa: Hartley Miller
22. Nama and Address of Facility: HARTLEY MILLER FUNERAL HOME, CHTD. 7527 HARFORD Rd. BALTIMORE, Md. 21234

Physician /Medical Examiner

23a. Part I. Enter tha disaase, or complications that caused the deeth. Do not antar the moda of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only ona cause on aach lina.

Approximete Intarval Between Onset end Death

Immediata Ceusa (Final diseesa or condition rasulting in deeth)
a. Chronic obstructive lung disease — many years
Dua to (or as a consequance of):
b.
Dua to (or as a consequance of):
c.
Due to (or es a consequence of):
d.

Sequentially list conditions, if eny, leading to immadiata causa. Enter Underlying Cause (Diseasa or injury that initiated evants resulting in death) Lest

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa givan in Part I.
Chronic renal failure
Advanced age

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Ware autopsy findings available prior to completion of cause of death? 1☐ Yas 2☐ No

25. Was casa referred to medical examiner? 1☐ Yas 2☑ No
28. Place of Death *(Check only ona)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatiant 3☐ DOA; Othar: 4☑ Nursing Home 5☐ Rasidance 6☐ Other *(Specify)*
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Panding investigation 6☐ Could not be datarmined
28a. Data of Injury *(Month, Day Yaar)*
28b. Tima of injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At homa, farm, street, factory, office building, atc. *(Specify)*
28f. Location *(Street and Number or Rural Routa Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To tha best of my knowledge, daath occurred at tha tima, data and place, and dua to tha cause(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha cause(s) and mannar stated.
29b. Signature and title of certifier: Carl Friedman
29c. Licensa number: D20688
29d. Data signed *(Month, Day, Yaar)*: 8/12/99
30. Nama and address of person who completed causa of death (Item 23a) (Type, Print): Carl S. Friedman, MD, 515 Fairmount Ave, Towson, Md. 21286

State Registrar

31. Data filad *(Month, Day, Yaar)*: AUG 16 1999
32. Registrar's Signature: D. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25618

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Gerson F. Kroiz
2. Data of Death: Month August Day 13 Year 1999
3. Tima of Daath: 12:30 AM
4a. Facility Nama (If not institution, give street and number): The Johns Hopkins Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-36-1948
6. Sex: 1 [X] M 2 [ ] F
7. Aga (In yrs. last birthday): 60 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): APR. 10, 1939
9. Birthplace (State or Foreign Country): PA

Usual Rasidance ot Decedent

10a. Steta: MD
10b. County: BALTIMORE
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 [ ] Yas 2 [X] No
10e. Street and Number: 220 CLARENDON AVENUE
10f. Zip Code: 21208
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Wes Decedent Ever in U.S. Armed Forcas? 1 [ ] Yas 2 [X] No — If Yes, Giva Yaar or Datas:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elamentary/Secondery (0-12): 4 — Collega (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): OWNER
16b. Kind of Business/Industry: REAL ESTATE

17. Father's Name (First, Middle, Last): SAMUEL KROIZ
18. Mother's Nama (First, Middle, Maiden Sumame): SARAH METZKER

19a. Interment's Neme/Raletionship (Type, Print): STANLEY KROIZ / BROTHER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 3601 GREENWAY - BALTIMORE, MD 21218

20a. Mathod of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Othar (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): BETH TFILOH CEMETERY
Data: 8/13/99
20c. Location - City or Town, Steta: WOODLAWN, MD

21. Signature of Funeral Sarvice Licensee: Robert Levinson
22. Name end Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part1. Entar the diseese, or complications that ceused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or haart failura. List only ona ceusa on aach lina.

Approximate Intarval Batween Onset and Death

Immediata Causa (Final disaasa or condition resulting in daath)
a. Pancreatic cancer — 1 Month
Dua to (or as e consequence of):

Sequentially list conditions, if any, leading to immadiata causa. Entar Underlying Cause (Disaase or Injury that initiated events rasulting in death) Last
b.
Dua to (or as a consequence of):
c.
Due to (or as e consequence of):
d.

Part tt. **Other elgnificant conditione** contributing to death but not rasulting in tha underlying ceusa given in Part I.

23b. Did tobacco uee contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No

24b. Wera autopsy findings available prior to completion of causa of death? 1 [ ] Yas 2 [X] No

25. Was case ratarred to medicet examinar? 1 [ ] Yas 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Homa 5 [ ] Residence 8 [ ] Othar (Specify)

27. Mannar of Death: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Panding invastigation 6 [ ] Could not be determined

28a. Deta ot Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28a. Place ot Injury - At homa, farm, street, factory, office building, atc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To tha best of my knowledga, daath occurred at the time, data and place, and due to the cause(s) end manner as stated. 2 [ ] **Medical Examiner:** On tha basis of examination and/or invastigation, in my opinion, deeth occurred et the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signeture end title of certifier: Dr. Deepak Kashyap
29c. License number: RES-000
29d. Deta signed (Month, Day, Year): August 13, 1999

30. Nema and address of person who complated ceuse ot deeth (Item 23a) (Type, Print): 600 North Wolfe Street Baltimore Maryland 21287

State Registrar

31. Data filed (Month, Day, Year): AUG 16 1999
32. Registrar's Signatura: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

A410

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25619

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joseph A Lee
2. Date of Death (Month, Day, Year): August 13, 1999
3. Time of Death: 11:30 AM
4a. Facility Name (If not institution, give street and number): Baltimore Rehabilitation & Extended Care
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N. A

Funeral Director

5. Social Security Number: 578 22 8692
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 74 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 6-14-25
9. Birthplace (State or Foreign Country): Wash. D.C

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Md
10b. County: N. A
10c. City, Town or Location: Balto.
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 1300 E. 36th St
10f. Zip Code: 21218
10g. Citizen of What Country? U. S. A

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No — If Yes, Give Year or Dates: 8/1945 - 7-30/46
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Postal Carrier
16b. Kind of Business/Industry: U.S. Post Office

17. Father's Name (First, Middle, Last): James Arthur Lee
18. Mother's Name (First, Middle, Maiden Surname): Mary Edith Randall

19a. Informant's Name/Relationship (Type, Print): Chicora Lee
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1300 E. 36th St Balto. Md 21218

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Garrison Forest — Date: 8/18/99
20c. Location - City or Town, State: Owings Mills. Md

21. Signature of Funeral Service Licensee: Joseph B. Locke Jr
22. Name and Address of Facility: Joseph B. Locke Jr F/H. 1304 N. Central Ave

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Cancer of lung — 2 month

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 ☒ **Yes** 2 ☐ **No** 3 ☐ **Probably** 4 ☐ **Unknown**

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Perry L. Colvin MD
29c. License number: D32548
29d. Date signed (Month, Day, Year): August 13, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PERRY L. COLVIN MD — 10 N Greene St Baltimore VA Medical Center

State Registrar

31. Date filed (Month, Day, Year): AUG 16 1999
32. Registrar's Signature: Lenora G. Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25620

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John C. Monmonier
2. Date of Death (Month, Day, Year): Aug. 13, 1999
3. Time of Death: 11:30 AM
4a. Facility Name (If not institution, give street and number): 2319 Birch Drive
4b. City, Town, or Location of Death: Woodlawn
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 705-05-2708
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 90 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 29, 1909
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Woodlawn
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2319 Birch Drive
10f. Zip Code: 21207
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+): 1
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerk
16b. Kind of Business/Industry: Balto. Ohio Railroad

17. Father's Name (First, Middle, Last): John F. Monmonier
18. Mother's Name (First, Middle, Maiden Surname): Mary Prunty

19a. Informant's Name/Relationship (Type, Print): Mr. Mark Monmonier - Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 302 Waldorf Parkway; Syracuse, New York 13224

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Balto. Washington Crem.
Date: 8/14/99
20c. Location - City or Town, State: Laurel, Maryland

21. Signature of Funeral Service Licensee: Stephen M. Jenkins
22. Name and Address of Facility: Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pancreatic cancer — 9 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Todd Heller
29c. License number: D38289
29d. Date signed (Month, Day, Year): August 13, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Todd - Heller ..1835 Greene Tree Road Baltimore Maryland 21208

State Registrar

31. Date filed (Month, Day, Year): AUG 16 1999
32. Registrar's Signature: Geneva B. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25621

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lillian Bayly Marks

2. Date of Death: Month: Aug Day: 13 Year: 1999

3. Time of Death: 1530

4a. Facility Name (If not institution, give street and number): St. Agnes Health Care 900 Caton Ave.

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

Funeral Director

5. Social Security Number: 213-03-8354

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 25, 1913

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 122 Woodlawn Avenue

10f. Zip Code: 21228

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Holmes R. Johnson

18. Mother's Name (First, Middle, Maiden Surname): Lillian Bayly

19a. Informant's Name/Reletionship (Type, Print): Bayly Janson-LaPalme (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7 Byford Court, Chestertown, Maryland 21620

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Loudon Park Cemetery

Date: 8/19/99

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Witzke Funeral Homes, Inc. 1630 Edmondson Avenue, Catonsville, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia — days

Due to (or as a consequence of):

b. Congestive heart failure — weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. pleural effusions — days

Due to (or as a consequence of):

d. Dehydration — days.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as steted. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J. Huefner MD [signature]

29c. License number: D47595

29d. Date signed (Month, Day, Year): August 13, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Julianne Huefner 1578 Sulphur Spring Road, Arbutus, MD 21227

State Registrar

31. Date filed (Month, Day, Year): AUG 16 1999

32. Registrar's Signature: [signature] B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

NAME Lillian Marks

W20

RKD

99-4660-013

EUGENE
MASON JR.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25622

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: EUGENE FRANCIS MASON, JR.
2. Date of Death — Month: AUGUST; Day: 11; Year: 1999
3. Time of Death: 1:35P.M.
4a. Facility Name *(If not institution, give street and number)*: 6300 BARNETT AVE
4b. City, Town, or Location of Death: SYKESVILLE
4c. County of Death: CARROLL

Funeral Director

5. Social Security Number: 013-40-0233
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 49 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 4/12/50
9. Birthplace *(State or Foreign Country)*: MASSACHUSETTS

Usual Residence of Decedent

10a. State: MD
10b. County: CARROLL
10c. City, Town or Location: SYKESVILLE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 6200 BARNETT AVENUE
10f. Zip Code: 21784
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12); College (1-4or 5+): 3 YEARS
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: MAINTENANCE
16b. Kind of Business/Industry: RESORT

17. Father's Name *(First, Middle, Last)*: EUGENE F. MASON, SR.
18. Mother's Name *(First, Middle, Maiden Surname)*: CESLAVA SOKOLOSKY

19a. Informant's Name/Relationship *(Type, Print)*: EUGENE F. MASON, SR. FATHER
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 124 WOODMONT ST. SPRINGFIELD, MA 01104

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: MATER DOLOROSA CEMETERY
Date: 8/16/99
20c. Location - City or Town, State: GREENFIELD, MA

21. Signature of Funeral Service Licensee
22. Name and Address of Facility: THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only *one* cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Atherosclerotic cardiovascular disease.
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: MORBID OBESITY. SEIZURE DISORDER

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? pending 1☑ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier
29c. License number: O.C.M.E.
29d. Date signed *(Month, Day, Year)*: AUGUST 12, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARYANN A. KOREN MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 16 1999
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25623

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Frances Marino

2. Date of Death (Month, Day, Year): June 30, 1999

3. Time of Death: 12:00 PM

4a. Facility Name (If not institution, give street and number): The John's Hpokins Hospital

4b. City, Town, or Location of Death: Baltimore, City

4c. County of Death:

Funeral Director

5. Social Security Number: 091-09-4046

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 8, 1910

9. Birthplace (State or Foreign Country): Brooklyn, NY

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Forest Hill

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 109 Forest Valley Drive

10f. Zip Code: 21050

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Diego Maracina

18. Mother's Name (First, Middle, Maiden Surname): Antonia Cerami

19a. Informant's Name/Relationship (Type, Print): Michael Marino, Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 41 Glenbrook Dr. Pheonix, MD 21131

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Calvary Cemetery

Date: June 3,1999

20c. Location - City or Town, State: Woodside, NY

21. Signature of Funeral Service Licensee: Michael L Bigler

22. Name and Address of Facility: Takoma Funeral Home 254 Carroll St, NW Washington, DC 20012

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Subdural Hematoma — Five days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia

Colon Cancer

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Amer Samdani, M.D.

29c. License number: Res 000

29d. Date signed (Month, Day, Year): July 29, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Amer Samdani, Johns Hopkins Hospital

State Registrar

31. Date filed (Month, Day, Year): AUG 16 1999

32. Registrar's Signature: [illegible] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25624

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): SYLVIA MATHENA
2. Date of Death (Month, Day, Year): AUGUST 12, 1999
3. Time of Death: 0251
4a. Facility Name (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 571-46-3651
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 63 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 3,1935
9. Birthplace (State or Foreign Country): Hawaii

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 28 Patapsco Ave.
10f. Zip Code: 21222
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 Years | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Nurse
16b. Kind of Business/Industry: Health Care Provider

17. Father's Name (First, Middle, Last): Henry Perry
18. Mother's Name (First, Middle, Maiden Surname): Florence Nunes

19a. Informant's Name/Relationship (Type, Print): Mr. Thomas E. Mathena/Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 28 Patapsco Ave. Dundalk, Maryland 21222

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Oak Lawn Cemetery | Date: 8/16/1999
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. LEFT VENTRICULAR RUPTURE — 2 MINUTES

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]
29c. License number: D47828
29d. Date signed (Month, Day, Year): 8/13/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John V. Conte, M.D. 600 N. Wolfe St. Blalock 618 Balto. MD. 21287

State Registrar

31. Date filed (Month, Day, Year): AUG 16 1999
32. Registrar's Signature: ▶ [signature] G. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25625

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JANIE MCDANIEL
2. Date of Death (Month, Day, Year): 08-12-99
3. Time of Death: 9:05 A.M.
4a. Facility Name (If not institution, give street and number): MILLENNIUM LIBERTY HGHTS
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212 80 5501
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 100 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 07-04-1899
9. Birthplace (State or Foreign Country): S.C.

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3247 BELMONT AVENUE
10f. Zip Code: 21216
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOUSEWIFE
16b. Kind of Business/Industry: HOME

17. Father's Name (First, Middle, Last): CHARLES DOUGLAS
18. Mother's Name (First, Middle, Maiden Surname): BELL CASON

19a. Informant's Name/Relationship (Type, Print): FLORENCE MYLES/DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3247 BELMONT AVENUE BALTO., MD. 21216

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): KING MEMORIAL PK
Date: 8/17/99
20c. Location - City or Town, State: BALTO., MD.

21. Signature of Funeral Service Licensee: James A. Morton
22. Name and Address of Facility: JAMES A. MORTON & SONS F.H., INC 1701 LAURENS ST. BALTO.,MD 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Metastatic breast cancer	6 mths
Due to (or as a consequence of): b.	atherosclerotic heart disease	10 yrs
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c.	congestive heart failure	5 yrs
Due to (or as a consequence of): d.	Hypertension	10 yrs

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D 30494
29d. Date signed (Month, Day, Year): 8/13/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DEAN I. MD 4660 Wilkens Ave Baltimore MD 21229

State Registrar

31. Date filed (Month, Day, Year): AUG 16 1999
32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25626

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ALBERTHA NELSON

2. Date of Death (Month, Day, Year): AUG 11 1999

3. Time of Death: 9:52pm

4a. Facility Name (If not Institution, give street and number): JOHN HOPKINS BAYVIEW MEDICAL CTR.

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 251-12-1536

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 02-28-11

9. Birthplace (State or Foreign Country): CHARLSTON, SC

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 4863 GREENCREST RD

10f. Zip Code: 21206

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify: X

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOUSEWIFE

16b. Kind of Business/Industry: DOMESTIC

17. Father's Name (First, Middle, Last): EMMITT MITCHELL

18. Mother's Name (First, Middle, Maiden Surname): FLORENCE MITCHELL

19a. Informant's Name/Relationship (Type, Print): WILLIE NELSON, SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4863 GREENCREST RD, BALTIMORE, MD 21206

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): ASHLEY MISSIONARY CEM

Date: 8-17-99

20c. Location - City or Town, State: CHARLSTON, SC

21. Signature of Funeral Service Licensee: ▶ Willie E Howell

22. Name and Address of Facility: WILLIE E. HOWELL/HOWELL FUNERAL HOME 4600 LIBERTY HGHTS AVE, BALTO., MD 21206

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Probable Myocardial Infarction — 6 HRS.

Due to (or as a consequence of):
b. Atherosclerotic Cardiovascular Disease 5 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. Diabetes Mellitus

Due to (or as a consequence of):
d. Essential Hypertension.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ E Ramesh

29c. License number: D 30641

29d. Date signed (Month, Day, Year): August 13th 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RAMESH SABAPATHY SUITE 308 821 N. EUTAW ST. BALTIMORE MD 21201

State Registrar

31. Date filed (Month, Day, Year): AUG 16 1999

32. Registrar's Signature: Linda G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

99-4692-005
JAD
Gloria Mae Perry
Unknown Female 99-179

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25627

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Gloria Mae Perry
2. Date of Death (Month, Day, Year): August 13, 1999
3. Time of Death: 4:55 PM
4a. Facility Name (If not institution, give street and number): Owings Mills Blvd.
4b. City, Town, or Location of Death: Owings Mills
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-32-8788
6. Sex: 1☐ M 2☒ F XX
7. Age (In yrs. last birthday): 61 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 10-08-37
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1901 E. Jefferson Street
10f. Zip Code: 21205
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No. If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No XX Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): [illegible]th Grade
College (1-4or 5+): 4yrs.
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homecare
16b. Kind of Business/Industry: Health Care Facilities

17. Father's Name (First, Middle, Last): Algie Perry
18. Mother's Name (First, Middle, Maiden Surname): Lillian Juggins

19a. Informant's Name/Relationship (Type, Print): Joyce Boyd
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1 Lochwell Court Baltimore, Maryland 21234

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Crestlawn Cemetery
Date: 08-19-99
20c. Location - City or Town, State: Howard, Co., MD

21. Signature of Funeral Service Licensee: Teresa Ly Canty
22. Name and Address of Facility: Baltimore, Maryland 21202
WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Multiple injuries
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? XX 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Scene

27. Manner of Death: 1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year): Aug. 13th 99
28b. Time of Injury: 4:30 PM
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: Lost control of car
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Street
28f. Location (Street and Number or Rural Route Number, City or Town, State): Owings Mills Blvd

29a. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated. 2☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: A. M. Dixon
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): August 14, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Mo., Day, Yr.): AUG 16 1999
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25628

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Sharon F. Roxin
2. Date of Death: Month: August; Day: 11; Year: 1999
3. Time of Death: 2130
4a. Facility Name (If not institution, give street and number): University of Maryland Hospital
4b. City, Town, or Location of Death: Baltimore, MD
4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 094-28-4454
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 63 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): DEC. 20, 1935
9. Birthplace (State or Foreign Country): NY

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7910 STEVENSON ROAD
10f. Zip Code: 21208
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 2; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ADMINISTRATOR
16b. Kind of Business/Industry: DENTISTRY

17. Father's Name (First, Middle, Last): DAVID LEISER
18. Mother's Name (First, Middle, Maiden Surname): HELEN OBLIGEN

19a. Informant's Name/Relationship (Type, Print): PAUL ROXIN / HUSBAND
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7910 STEVENSON ROAD - BALTIMORE, MD 21208

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MIKRO KODESH BETH ISRAEL
Date: 8/13/99
20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee: Robert Levinson
22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. FULMINANT HEPATIC FAILURE

Due to (or as a consequence of):
b. Transplant liver thrombosis

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Necrotizing pancreatitis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Lisa Niparko
29c. License number: P12456
29d. Date signed (Month, Day, Year): August 11, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): LISA NIPARKO 22 South Greene St Baltimore, MD

State Registrar

31. Date filed (Month, Day, Year): AUG 16 1999
32. Registrar's Signature: Lenora G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

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To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

AH 5

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25629

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Dey Year	3. Time of Death
Charles L. Smith	AUGUST, 11, 1999	0830

4a Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
St. Agnes Hospital	Baltimore	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Dey, Year)	9. Birthplece (State or Foreign Country)
217-22-8299	1☒M 2☐F	93 Yrs.			August 2,1906	Maryland

Usuel Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD		Baltimore	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5106 Edmondson Avenue	21229	U.S.A.

11. Maritel Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Bleck, White, etc.
1☐Never Merried 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retirad)	16b. Kind of Business/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)		
10		Manufactor Representative	Charles L. Smith

17. Father's Name (First, Middle, Last)	18. Mother's Neme (First, Middle, Meiden Surneme)
Albert Smith	Josephine Mills

19a. Intormant's Neme/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)
Russell L. Miller (Nephew)	1203 Molesworth Road, Parkton, MD 21120

20e. Method of Disposition	20b. Piece of Disposition (Neme of cemetery, cremetory or other piece)	Dete	20c. Location - City or Town, State
1☐Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☒Other (Specify) Entombment	Lorraine Park Mausoleum	8/13/99	Woodlawn, Maryland

21. Signature of Funeral Service Licensee	22. Name end Address of Facility
▶ [signature]	Witzke Funeral Homes, Inc. 1630 Edmondson Avenue, Catonsville, MD 21228

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heert tailure. List only one cause on each line.

		Approximate Interval Between Onset end Death
Immediate Cause (Finel disease or condition resulting in death)	a. Myocardial Infarction secondary to Atherosclerotic Coronary Vessel Disease	1 hour
Due to (or as a consequence of):	b. Diabetes	
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest	Due to (or as e consequenca of): c.	
	Due to (or es e consequenca of): d.	

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart failure

23b. Did tobacco use contribute to the cause of death?	24e. Was an autopsy performed?	24b. Were autopsy findings eveilable prior to completion ot cause ot death?
1☐Yes 2☐No 3☐Probably 4☒Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☒ER/Outpetient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Deeth	28a. Date ot Injury (Month, Dey Yeer)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28t. Location (Street and Number or Rural Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and place, and due to the ceuse(s) end menner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] MD	D50708	August 11, 1999 21229

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)
Kraig A. Melville MD 900 South Caton Avenue, Baltimore, MD

State Registrar

31. Date filed (Month, Day, Year)	32. Registrer's Signeture
AUG 16 1999	[signature] G. Sparks

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

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Division of Vital Records, P.O. Box 68760,

Smith, Charles L

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25630

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Julie Susan Smith
2. Date of Death Month Day Year: August 14, 1999
3. Time of Death: 2:30PM
4a. Facility Name *(If not institution, give street and number)*: 5732 Yellowrose Court
4b. City, Town, or Location of Death: Columbia
4c. County of Death: Howard

Funeral Director

5. Social Security Number: 579-42-9235
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 65 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: August 17, 1933
9. Birthplace *(State or Foreign Country)*: Connecticut

Usual Residence of Decedent

10a. State: MD
10b. County: Howard
10c. City, Town or Location: Columbia
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 5732 Yellowrose Court
10f. Zip Code: 21045
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Financial Analyst
16b. Kind of Business/Industry: Treasury Department U.S. Government

17. Father's Name *(First, Middle, Last)*: Joel Rogers
18. Mother's Name *(First, Middle, Maiden Surname)*: Winifred Whitehouse

19a. Informant's Name/Relationship *(Type, Print)*: Julie L. Elrod (Daughter)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8648 Open Meadow Way, Columbia, MD 21045

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Balt./Wash. Crematory | Date: Aug. 16, 1999
20c. Location - City or Town, State: LAUREL, MD

21. Signature of Funeral Service Licensee: ▶ Robert Gregory Brehm
22. Name and Address of Facility: Witzke Funeral Homes, Inc. 5555 Twin Knolls Road, Columbia, MD 21045

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Respiratory Failure — 2 weeks

Due to (or as a consequence of):
b. Breast Cancer metastatic to lungs, liver, & yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. bone.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic anemia

Malnutrition

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Jon K. Mumford
29c. License number: D30573
29d. Date signed *(Month, Day, Year)*: 8-16-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jon K. Mumford, MD 21065 Hilltop Patuxent Parkway Columbia, MD.

State Registrar

31. Date Filed *(Month, Day, Year)*: AUG 16 1999
32. Registrar's Signature: ▶ Bruce D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

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To Be Completed by Funeral Director

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25631

DEBORAH STEIN AUGUST 13, 1999 4:45 a.m.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: DEBORAH L. STEIN
2. Date of Death Month / Day / Year: AUGUST 13 1999
3. Time of Death: 4:45 am
4a. Facility Name *(If not institution, give street and number)*: STELLA MARIS HOSPICE
4b. City, Town, or Location of Death: TOWSON
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 218689134
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 42 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: NOV 10 1956
9. Birthplace *(State or Foreign Country)*: MARYLAND

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: RASPEBURG
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 4600 HELLWIG ROAD
10f. Zip Code: 21206
10g. Citizen of What Country?: USA
11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 0
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: SECRETARY
16b. Kind of Business/Industry: OFFICE
17. Father's Name *(First, Middle, Last)*: PAUL S. MERRILL
18. Mother's Name *(First, Middle, Maiden Surname)*: PATRICIA CROMER
19a. Informant's Name/Relationship *(Type, Print)*: KARL C. STEIN / HUSBAND
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4600 HELLWIG ROAD BALTIMORE, MD 21206
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: GARDENS OF FAITH
Date: 8/16/99
20c. Location - City or Town, State: BALTIMORE, MD
21. Signature of Funeral Service Licensee
22. Name and Address of Facility: CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVENUE BALTO., MD 21237

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. BREAST CANCER
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* HOSPICE

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of Certifier
29c. License number: D43725
29d. Date signed *(Month, Day, Year)*: 8/14/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 16 1999
32. Registrar's Signature: Irma G. Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

4718

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25632

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): THELMA THERESA SNYDER
2. Date of Death (Month, Day, Year): AUGUST 13, 1999
3. Time of Death: 8:55 P.M.
4a. Facility Name (If not institution, give street and number): CHARLESTOWN CARE CENTER
4b. City, Town, or Location of Death: CATONSVILLE
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 219-18-0353
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 92 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 4/20/07
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: PARKVILLE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3339 WILLOUGHBY ROAD
10f. Zip Code: 21234
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th GRADE | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): WILLIAM MCGANN
18. Mother's Name (First, Middle, Maiden Surname): NELLIE BOLAND

19a. Informant's Name/Relationship (Type, Print): BERNICE KUCHTA DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3339 WILLOUGHBY ROAD BALTIMORE, MD 21234

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MORELAND MEMORIAL PARK
Date: 8/16/99
20c. Location - City or Town, State: HILLENDALE, MD

21. Signature of Funeral Service Licensee
22. Name and Address of Facility: THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pulmonary Embolism — minutes

Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Dementia — years
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D47447
29d. Date signed (Month, Day, Year): August 14, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Andrew Cazis 711 Maiden Choice Lane Catonsville Maryland

State Registrar

31. Date filed (Month, Day, Year): AUG 16 1999
32. Registrar's Signature: Linda B. Sparks

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To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Name: Thelma Snyder

445

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25633

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: William Randall Smith
2. Date of Death Month: Aug Day: 9 Year: 1999
3. Time of Death: 12:20
4a. Facility Name *(If not institution, give street and number)*: Washington County Hospital
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 219-52-2239A
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 49 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: August 5, 1950
9. Birthplace *(State or Foreign Country)*: WV

Usual Residence of Decedent

10a. State: MD
10b. County: Washington
10c. City, Town or Location: Hancock
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 2 Hillside Street
10f. Zip Code: 21750
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 8 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Fork Lift Operator
16b. Kind of Business/Industry: Tannery

17. Father's Name *(First, Middle, Last)*: James E. Smith
18. Mother's Name *(First, Middle, Maiden Surname)*: Alda Virginia Clingerman

19a. Informant's Name/Relationship *(Type, Print)*: Wilma L. Smith/Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2 Hillside Street Hancock, MD 21750

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Black Oak Mennonite Cem. — Date: 8/13/99
20c. Location - City or Town, State: Warfordsburg, PA

21. Signature of Funeral Service Licensee: Richard L. Grove
22. Name and Address of Facility: Grove Funeral Home, P.A. 141 W.Main St.Hancock,MD 21750-0368

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cardiac arrhythmia	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Colmary artery disease	
	Due to (or as a consequence of):	
	c. hypertension	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

End Stage renal disease
Insulin dependent diabetes mellitus

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [ ] inpatient 2 [X] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Richard L. Grove
29c. License number: D20231
29d. Date signed *(Month, Day, Year)*: 8/9/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BAPURAO PULIVARTI, MD 12931 Oakhill Ave, Hagerstown MD 21742

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 16 1999
32. Registrar's Signature: Brenda G. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

Smith, William

AHS

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25634

Physician /Medical Examiner

1. Decedent's Nema *(First, Middle, Last)*: AGNES THERESA SGROI
2. Date of Death Month Day Year: August 12, 1999
3. Time of Death: 8:45AM
4a. Facility Name *(If not institution, give street and number)*: Manor Care Health Services
4b. City, Town, or Location of Death: Rossville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 218-05-1798
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 78 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: April 20, 1921
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. Stete: Maryland
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1929 Cedar Lane
10f. Zip Code: 21222
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Merried 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Wes Decedenl of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 9 Years; College (1-4or 5+):
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Neme *(First, Middle, Last)*: Michael Pijanowski
18. Mother's Name *(First, Middle, Maiden Surname)*: Anna Marcinko

19e. Informant's Neme/Reletionship *(Type, Print)*: Husband Mr. Joseph J. Sgroi, Sr.
19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1929 Cedar Lane Dundalk, Maryland 21222

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stete 4☐ Donation 5☐ Other *(Specify)*
20b. Piece of Disposition *(Name of cemetery, crematory or other place)*: Holy Rosary Cemetery
Date: 8/14/1999
20c. Location - City or Town, State: Dundalk, Maryland

21. Signeture of Funeret Service Licensee
22. Name end Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediete Cause (Final diseese or condition resulting in death): a. CoPD — 1 year

Due to (or as e consequence of):

Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last

b.

Due to (or es e consequence of):

c.

Dua to (or es a consequance of):

d.

Part II. **Other significant conditions** contributing lo death but not resulting in the underlying cause given in Part I.

23b. Did tobecco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medicat examiner? 1☐ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier
29c. License number: D45475
29d. Date signed *(Month, Day, Year)*: 8/13/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): M. Rahnama M.D. 17 Fontana Lane Suite 105 Baltimore, Maryland 21237

State Registrar

31. Dete filed *(Month, Day, Year)*: AUG 16 1999
32. Registrar's Signature: Irma G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indeiible Ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25635

Tolbert, Mary

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
MARY AMELIA TOLBERT	AUGUST 13 1999	3:30pm

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
LORIEN-RIVERSIDE NURSING & REHAB CENTER	BELLCAMP	HARFORD

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-22-6023	1☐ M 2☒ F XX	87 Yrs.			MAR 9 1912	MARYLAND

Usual Residence of Decedent

10e. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	HARFORD CO	CONOWINGO	1☒ Yes X 2☐ No X

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
270 MT. ZORA ROAD	21718	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed XX 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No XX Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elamantary/Secondary (0-12)	College (1-4or 5+)		
7th grade		HOUSEWIFE	DOMESTIC

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
BENJAMIN BROWN	PAULINE HAINES BROWN

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Carlton E. Tolbert/Son	WILLIAM C BROWN COMMUNITY FUNERAL HOME PA-HARFORD 321 S PHILADELPHIA BLVD ABERDEEN MARYLAND 21001

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other piece)	Date	20c. Location - City or Town, State
1☒ Burial XX 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)	MT ZOAR A.M.E. CHURCH	8-17-99	CONOWINGO, MARYLAND

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Barbara H. Brown	WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 321 S.PHILADELPHIA BLVD ABERDEEN, MD 21001

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or haart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final diseasa or condition resulting in death)	a. Cerebrovascular Accident	within an hour
	Dua to (or as a consaquance of):	
Sequentially list conditions, if any, leading to Immediata cause. Enter Underlying Cause (Diseasa or injury that initiated evants resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or es e consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying cause given in Part I.

Previous Right thalamic Hemorrhage with Intraventricular Extension

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performad?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yas 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Placa of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☒ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how Injury occurred
1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledga, death occurred at the tima, date and place, and due to the cause(s) and manner es stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and menner steted.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ MD	D19583	August 13, 1999

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

MANUEL M. KAZZIN, MD 5 Law Street 21001 Aberdeen, Maryland

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
AUG 16 1999	Regina D. Sparks

DHMH 16 Rev 6/95

AHC

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25636

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Timothy F. Thompson
2. Date of Death (Month, Day, Year): August 13, 99
3. Time of Death: 9:17am
4a. Facility Name (If not institution, give street and number): 623 North Potomac Street
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: NA

Funeral Director

5. Social Security Number: 213-86-0808
6. Sex: 1 X M 2 ☐ F
7. Age (In yrs. last birthday): 34 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 08-29-64
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 X Yes 2 ☐ No
10e. Street and Number: 623 N. Potomac Street
10f. Zip Code: 21205
10g. Citizen of What Country?: USA

11. Marital Status: 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes X ☐ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): High Sch. Grad | College (1-4or 5+): NA
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Correctional Officer
16b. Kind of Business/Industry: State of Maryland

17. Father's Name (First, Middle, Last): Wilbert Thompson
18. Mother's Name (First, Middle, Maiden Surname): Carloyn Robinson

19a. Informent's Name/Relationship (Type, Print): Carolyn Wilson
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 623 N. Potomac Street Baltimore, Maryland 21205

20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Parkwood Cemetery | Date: 08-17-99
20c. Location - City or Town, State: Parkville, MD

21. Signature of Funeral Service Licensee: Bernard D Johnson
22. Name and Address of Facility: Baltimore, Maryland 21202
WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. HIV Leukoencephalopathy — 6 months
Due to (or as a consequence of):
b. Acquired Immunodeficiency Syndrome — 3 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as e consequence of):
c.
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X ☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 X ☐ No

25. Was case referred to medical examiner? 1 X Yes 2 ☐ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 X ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 X Neturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jeffrey Lance Magaziner
29c. License number: D00 51944
29d. Date signed (Month, Day, Year): August 16, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jeffrey Lance Magaziner, 501 N. Caroline St, Baltimore, MD 21287

State Registrar

31. Date filed (Month, Day, Year): AUG 16 1999
32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25637

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: George Triktis

2. Dete of Deeth: Month 8 Dey 11 Yeer 99

3. Time of Death: 10:41 AM

4e. Feciity Neme *(If not institution, give street end number)*: John Hopkins Bayview Med. Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Deeth: N/A

Funeral Director

5. Sociel Security Number: 216-28-4629

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. lest birthday)*: 67 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Day, Yeer)*: Jan.12,1932

9. Birthplece *(Stete or Foreign Country)*: Balto,Md

Usuel Residence of Decedent

10a. Stete: Md

10b. County: Balto.

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 4322 Plainfield Ave

10f. Zip Code: 21206

10g. Citizen of Whet Country?: U.S.A.

11. Meritel Stetus: 1 [ ] Never Merried 2 [X] Merried 3 [ ] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U,S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yeer or Detes: Korea

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Rece - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12 / College (1-4or 5+):

16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Restauratuer

16b. Kind of Business/Industry: Food

17. Father's Neme *(First, Middle, Last)*: George Lagoumis

18. Mother's Neme *(First, Middle, Meiden Surneme)*: Faith Maria Floros

19a. Informent's Neme/Reletionship *(Type, Print)*: Tina Triktis / Wife

19b. Meiling Address *(Street and Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 4322 Plainfield Ave.,Balto.,Md. 21206

20e. Method of Disposition: 1 [X] Buriel 2 [ ] Cremetion 3 [ ] Removel from Stete 4 [ ] Donetion 5 [ ] Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other place)*: Oak Lawn Cemetery

Dete: 8-14-99

20c. Location - City or Town, Stete: Balto.,Md.

21. Signeture of Funerel Service Licensee: Ann S. Matthews

22. Neme end Address of Feciity: Bradley-Ashton-Matthews Funeral Home, Inc. 2134 Willow Spring Rd.,Balto.,Md. 21222

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complicetions thet cesused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Intervel Between Onset and Deeth

Immediate Cause (Finel disease or condition resulting in deeth) e. Acute necrotizing pancreatitis — 2 months

Due to (or as a consequence of):

Sequentielly list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Diseese or Injury thet initiated events resulting in deeth) Lest

b. Due to (or es e consequence of):

c. Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings aveilable prior to completion of cause of deeth? 1 [ ] Yes 2 [X] No

25. Wes case referred to medical exeminer? 1 [ ] Yes 2 [X] No

26. Piece of Death *(Check only one)*: Hospital: 1 [X] Inpetient 2 [ ] ER/Outpetient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Deeth: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Dete of Injury *(Month, Dey Yeer)*

28b. Time of injury M

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end place, end due to the cause(s) and menner as stated. 2 [ ] **Medical Examiner:** On the basis of exemineticn end/or investigation, in my opinion, death occurred at the time, dete and place, end due to the cause(s) end menner steted.

29b. Signeture end title of certifier: Christopher G. Williams Christopher G. Williams

29c. License number: Res-000

29d. Dete signed *(Month, Day, Yeer)*: 8/11/99

30. Neme end address of person who completed cause of death (Item 23a) (Type, Print): CHRISTOPHER G. WILLIAMS JOHNS HOPKINS BAYVIEW

State Registrar

31. Dete filed *(Month, Day, Yeer)*: AUG 16 1999

32. Registrar's Signeture: Linnea B. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25638

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): SHIRLEY PATRICIA TURNBAUGH

2. Date of Death: Month August Day 14 Year 1999

3. Time of Death: 0716

4a. Facility Name (If not institution, give street and number): Sinai Hospital of Baltimore

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: City

Funeral Director

5. Social Security Number: 213-40-0199

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 58 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept. 24, 1940

9. Birthplace (State or Foreign Country): Balto. Co. Md.

Usual Residence of Decedent

10a. State: Md.

10b. County: Baltimore

10c. City, Town or Location: Reisterstown

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 832 Shirley Manor Road

10f. Zip Code: 21136

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12 Grade

College (1-4 or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): American Expeditiny Co.

16b. Kind of Business/Industry: Caurier

17. Father's Name (First, Middle, Last): James McCloskey

18. Mother's Name (First, Middle, Maiden Surname): Audrey Bull

19a. Informant's Name/Relationship (Type, Print): Kenneth A. Rice (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 832 Shirley Manor Rd. Reisterstown, Md.

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Carroll Cremation Service

Date: 8/15/99

20c. Location - City or Town, State: Hampstead, Md.

21. Signature of Funeral Service Licensee: Elmer B. Eline

22. Name and Address of Facility: ELINE FUNERAL HOME 11824 Reisterstown Road Reisterstown, Md. 21136

Physician /Medical Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. metastatic pancreatic cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

respiratory failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: James Black

29c. License number: RES 000

29d. Date signed (Month, Day, Year): August 14, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): James Black ... Sinai Hospital of Baltimore

State Registrar

31. Date filed (Month, Day, Year): AUG 16 1999

32. Registrar's Signature: Linda B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Jan Turnbaugh Shirley

4

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25639

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ANNA TAYLOR

2. Date of Death: Month July Day 30 Year 1999

3. Time of Death: 205 AM

4a. Facility Name (If not institution, give street and number): Genesis Eldercare

4b. City, Town, or Location of Death: Catonsville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-05-2491

6. Sex: 1☐ M 2☑ F

7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept. 16, 1911

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1☐ Yes 2☑ No

10e. Street and Number: 16 Fusting Ave.

10f. Zip Code: 21228

10g. Citizen of What Country? USA

11. Marital Status: 1☑ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): unk.

16b. Kind of Business/Industry: unk.

17. Father's Name (First, Middle, Last): unk.

18. Mother's Name (First, Middle, Maiden Surname): unk.

19a. Informant's Name/Relationship (Type, Print): Edward L. Zamarin

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12 Homeland Ave Balto., MD. 21212

20a. Method of Disposition: 1☐ Burial 2☑ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory

Date:

20c. Location - City or Town, State: Catonsville, MD.

21. Signature of Funeral Service Licensee: Gary P. March

22. Name and Address of Facility: Gary P. March Funeral Home P.A. 270 Fredhilton Place Balto., MD. 21229

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Atherosclerotic Cardiovascular Disease — 3 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Edward P. March

29c. License number: D34951

29d. Date signed (Month, Day, Year): 8-3-99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Edmund P. March 405 Frederick Rd Catonsville MD 21228

State Registrar

31. Date filed (Month, Day, Year): AUG 16 1999

32. Registrar's Signature: Sandra B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25640

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Rosa E. Vanskiver

2. Date of Death — Month: August; Day: 13; Year: 1999

3. Time of Death: 3:35 p.m.

4a. Facility Name *(If not institution, give street and number)*: Genesis Eldercare - Hammonds Lane

4b. City, Town, or Location of Death: Brooklyn Park

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 215-09-4753

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 93 Yrs.

If Under 1 Year — Months: ; Days: ; If Under 24 Hrs. — Hours: ; Min.:

8. Date of Birth *(Month, Day, Year)*: January 8, 1906

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Brooklyn Park

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 305 16th Avenue

10f. Zip Code: 21225

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: General Work

16b. Kind of Business/Industry: Glass Company

17. Father's Name *(First, Middle, Last)*: Robert Vanskiver

18. Mother's Name *(First, Middle, Maiden Surname)*: Alverta Hissey

19a. Informant's Name/Relationship *(Type, Print)*: Edward Wirt, Jr. - great nephew

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 304 Blue Water Ct., #103, Glen Burnie, MD 21061

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Meadowridge Memorial Park

Date: 8/16/99

20c. Location - City or Town, State: Elkridge, Maryland

21. Signature of Funeral Service Licensee: Steven H. Williams, M00986

22. Name and Address of Facility: Gary L. Kaufman Funeral Home @ Meadowridge Memorial Park Inc 7250 Washington Blvd., Elkridge, MD 21075

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Congestive Heart Failure

Due to (or as a consequence of):
b.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

26e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

26f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]

29c. License number: D46816

29d. Date signed *(Month, Day, Year)*: 8/15/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Chopra, Genesis Elder Care - Hammonds Lane, Baltimore, Md.

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 16 1999

32. Registrar's Signature: G. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25641

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JACK WILLIAM WEINBERG

2. Date of Death (Month, Day, Year): AUGUST 10, 1999

3. Time of Death: 2:40 PM

4a. Facility Name (If not institution, give street and number): SUBURBAN HOSPITAL

4b. City, Town, or Location of Death: BETHESDA

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 578-07-8868

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): DEC. 25, 1915

9. Birthplace (State or Foreign Country): POLAND

Usual Residence of Decedent

10a. State: MD

10b. County: MONTGOMERY

10c. City, Town or Location: SILVER SPRING

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 8715 1ST AVENUE #703-D

10f. Zip Code: 20910

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yas 2 [X] No Specify:

14. Race - American Indian, Black, Whita, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 1

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired): SALESMAN

16b. Kind of Business/Industry: MENS CLOTHING

17. Father's Nama (First, Middle, Last): MORRIS WEINBERG

18. Mother's Name (First, Middle, Maiden Surname): HELEN FRIED

19a. Informant's Name/Relationship (Type, Print): FRIEDA LENORA WEINBERG / WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7224 CADENCE COURT - COLUMBIA, MD 21046

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [X] Removal from Stata 4 [ ] Donatica 5 [ ] Other (Specify)

20b. Place of Disposition (Nama of cematary, crematory or othar place): KING DAVID MEMORIAL GARDENS

Date: 8/13/99

20c. Location - City or Town, Stata: FALLS CHURCH, VA

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part1. Enter the disease or complications that caused the death. Do not entar tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on aach line.

Approximata Intervel Between Onset and Death

Immediata Cause (Final diseasa or condition resulting in death): a. Atherosclerotic Coronary Artery Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as e consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in tha underlying causa given in Part I.: Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yas 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be detarmined

28a. Data of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at tha tima, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Katharine R. Lillie, MD

29c. Licensa number: D53244

29d. Date signed (Month, Day, Year): August 11, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Katharine R. Lillie, MD 11140 Rockville Pike #348, Rockville, MD 20852

State Registrar

31. Data filed (Month, Day, Year): AUG 16 1999

32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Art Dt / Jack Weinberg 08/10/99 2:40 pm

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25642

AMEND #17 PER F.H. G774 8-18-99 J.A.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY A Britt-Wilson
2. Date of Death (Month, Day, Year): August 11 1999
3. Time of Death: 7:45pm
4a. Facility Name (If not institution, give street and number): Bon Secour Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: NA

Funeral Director

5. Social Security Number: 246-48-5418
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 67 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 04-27-32
9. Birthplace (State or Foreign Country): NC

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: X1☒ Yes 2☐ No
10e. Street and Number: 2019 North Longwood Street
10f. Zip Code: 21216
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9th Grade | College (1-4or 5+): NA
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cashier
16b. Kind of Business/Industry: Rite Aide Pharmacy

17. Father's Name (First, Middle, Last): JOHN ~~Henry~~ Britt
18. Mother's Name (First, Middle, Maiden Surname): Annie Royal

19a. Informant's Name/Relationship (Type, Print): Henry Wilson
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2019 N. Longwood Street Baltimore, Md. 21216

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Hillside Cemetery | Date: 08-19-99
20c. Location - City or Town, State: Smithfield, NC

21. Signature of Funeral Service Licensee: Terrance L Lamb
22. Name and Address of Facility: Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. End Stage Chronic OBSTRUCTIVE pulmonary Disease
Due to (or as a consequence of):
b. LUNG CANCER

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Gastro Intestinal Bleeding
Due to (or as a consequence of):
d. Cardiac arrhyma

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Terance Lamb M.D
29c. License number: D37203
29d. Date signed (Month, Day, Year): August 11 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): TERANCE L. LAMB Bon Secours Hospital Baltimore, Md 21223

State Registrar

31. Date filed (Month, Day, Year): AUG 16 1999
32. Registrar's Signature: G. Sparks

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ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25643

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LAWRENCE W. WELLS
2. Date of Death (Month, Day, Year): AUGUST 7, 1999
3. Time of Death: 2:A.M

4a. Facility Name (If not institution, give street and number): 819 QUEENSTOWN ROAD (HOME)
4b. City, Town, or Location of Death: SEVERN, MD.
4c. County of Death: ANNE ARUNDELCO.

Funeral Director

5. Social Security Number: 709-12-4668
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): DEC 24, 1909
9. Birthplace (State or Foreign Country): HARMANS, MD.

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: SEVERN
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 819 QUEENSTOWN ROAD
10f. Zip Code: 21144
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Detes: 43-45
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: AFRO AMERICAN

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): RAIL ROAD - PULLMAN
16b. Kind of Business/Industry: RAILROAD CO.

17. Father's Name (First, Middle, Last): WILLIAM E. WELLS
18. Mother's Neme (First, Middle, Maiden Surneme): NETTIE J. TOYER

19a. Informant's Neme/Relationship (Type, Print): WENDY L. SIMMS DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 819 QUEENSTOWN RD, SEVERN, MARYLAND 21144

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removal from Stete 4 [ ] Donation 5 [ ] Other (Specify)
20b. Piece of Disposition (Neme of cemetery, crematory or other place): STAINTS REST CEMETERY | Dete: 8/12/99
20c. Location - City or Town, State: HANOVER, MD.

21. Signature of Funeral Service Licensee: LLOYD M. ESTEP Lloyd M. Estep
22. Name end Address of Fecility: ESTEP BROTHERS FUNERALSER, P A. 1300 EUTAW PLACE, BALTIMORE, MARYLAND 21217

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. (Approximete Interval Between Onset and Deeth)

Immediate Cause (Finel disease or condition resulting in death): a. CARDIOPULMONARY ARREST
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or es a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably [X] Unknown

24a. Wes en autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings aveilable prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Piece of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end piece, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the ceuse(s) and manner steted.

29b. Signature and title of certifier:
29c. License number: 025782
29d. Date signed (Month, Day, Year): 08/10/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. STEPHAM IZZI 7575 RITCHIE HIGHWAY, GLEN BURNIE, MARYLAND.

State Registrar

31. Date filed (Month, Day, Year): AUG 16 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25644

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lillian M. Zalis
2. Date of Death: Month August, Day 11, Year 1999
3. Time of Death: 3:45pm
4a. Facility Name (If not institution, give street and number): Sinai Hospital of Baltimore
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-01-1617
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): OCT. 1, 1913
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3601 CLARKS LANE #310
10f. Zip Code: 21215
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): NATHAN MICHAELSON
18. Mother's Name (First, Middle, Maiden Surname): FRIEDA SCOY

19a. Informant's Name/Relationship (Type, Print): FRANCES GROSSMAN / DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12 ALDERSGATE COURT - RANDALLSTOWN, MD 21133

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): BETH TFILOH CEMETERY
Date: 8/13/99
20c. Location - City or Town, State: WOODLAWN, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): e. Cerebral Vascular Accident

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Congestive Heart Failure, Renal Insufficiency, Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29e. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] Donald Bauer, M.D.
29c. License number: D36353
29d. Date signed (Month, Day, Year): 8/11/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 2411 W. Belvedere Ave Suite 302 Baltimore, MD 21215

State Registrar

31. Date filed (Month, Day, Year): AUG 16 1999
32. Registrar's Signature: [signature] G. Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

DHMH 16 Rev 6/95

AH 12

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25645

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Carmela Ida Arbogast

2. Dete of Deeth: Month: August; Dey: 15; Year: 1999

3. Time of Deeth: 10:10 am

4a. Facility Nama *(If not institution, giva street and number)*: Anne Arundel Medical Center

4b. City, Town, or Location of Death: Annapolis

4c. County of Deeth: Anne Arundel

Funeral Director

5. Social Security Number: 579-26-0803

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 73 Yrs.

If Under 1 Year: Months: ; Days:

If Under 24 Hrs.: Hours: ; Min.:

8. Dete of Birth *(Month, Day, Year)*: March 27,1926

9. Birthplece *(State or Foraign Country)*: New York

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Crownsville

10d. Insida City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 1057 Plum Creek Drive

10f. Zip Code: 21032

10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐ Never Marriad 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedant Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Giva Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, atc.) 1☐ Yes 2☒ No *Specify:*

14. Race - Amarican Indian, Black, Whita, atc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10; Collega (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use ratired)*: Military Personnel Technician

16b. Kind of Business/Industry: Dept. of Defense

17. Father's Neme *(First, Middle, Last)*: Adriano Bartoletti

18. Mother's Neme *(First, Middle, Maiden Sumame)*: Edemia Botega

19a. Informant's Neme/Relationship *(Type, Print)*: Rosemary J. Arbogast (Daughter)

19b. Meiting Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1057 Plum Creek Dr., Crownsville, MD 21032

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removal from Stete 4☐ Donation 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cematary, crematory or other piece)*: Our Lady of the Fields

Date: 08/20

20c. Location - City or Town, State: Millersville, MD

21. Signature of Funeral Service Licensee: Michele G. Hutto

22. Name end Address of Facility: Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert failure. List only one cause on aach line.

Approximete Intervet Between Onset end Death

Immediate Cause (Final diseese or condition resulting in deeth)

e. ASPIRATION PNEUMONIA — 2 DAYS

Due to (or es e consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in death) Last

b. SQUAMOUS CELL CANCER EPIGLOTTIS — 1 YEAR

Due to (or es e consequence of):

c.

Due to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa given in Part I.

CORONARY ARTERY DISEASE

CHRONIC RENAL FAILURE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings evaitable prior to completion of causa of death? N/A 1☐ Yas 2☐ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No

26. Piece of Death *(Check only one)*: Hospitel: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*: N/A

28b. Time of Injury: M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and piece, end due to the ceuse(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or Investigetion, In my opinion, death occurred at the time, dete end ptece, and due to the cause(s) end menner steted.

29b. Signature and title of certifier: DS MITCHELL

29c. License number: D39037

29d. Data signed *(Month, Dey, Year)*: 8/15/99

30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print): DOUGLAS S MITCHELL, ANNE ARUNDEL MEDICAL CENTER

State Registrar

31. Date filed *(Month, Dey, Year)*: AUG 17 1999

32. Registrar's Signetura: G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

8

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25646

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: CHARLOTTE ALLEN

2. Date of Death Month / Day / Year: AUGUST 13 1999

3. Time of Death: 10:00 PM

4a. Facility Name *(If not institution, give street and number)*: HARBOR HOSPITAL CENTER

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: n/a

Funeral Director

5. Social Security Number: 217-84-1211

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 35 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Nov. 11 1963

9. Birthplace *(State or Foraign Country)*: Maryland

Usual Residence of Decedent

10a. State: Md.

10b. County: n/a

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 4142 Mariban Court

10f. Zip Code: 21225

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Navar Marriad 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yas 2☐ No If Yes, Give Year or Dates: X

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yas 2☒ No Specify: X

14. Race - American Indian, Black, Whita, etc. Specify: white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 | Collega (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work dona during most of working life. DO NOT use retired)*: Housewife

16b. Kind of Business/Industry: Home Owner

17. Father's Name *(First, Middle, Last)*: John L. Bury

18. Mother's Name *(First, Middle, Maiden Sumama)*: Shirley J. Moore

19a. Informant's Name/Ralationship *(Type, Print)*: Dorthea L. Grewe (Aunt)

19b. Mailing Address *(Straat and Number or Rural Route Number, City or Town, State, Zip Code)*: 4450 Shannon Way, Port Republic, Md. 20676

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Green Mount Cemetery

Date: 8/17/99

20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: Daniel C. Hayes

22. Name and Address of Facility: McCully-Polyniak Funeral Home P.A. 237 E. Patapsco Ave., Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrast, shock, or haart failure. List only one cause on each line.

Approximate Interval Between Onsat and Death

Immediate Cause (Final disaase or condition resulting in death)
a. SEPTICEMIA — 3 days

Dua to (or as a consequanca of):

Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Causa (Disaase or injury that initiated events resulting in death) Last
b. SACRAL DECUBITUS ULCER

Due to (or as a consequence of):

c.

Dua to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Were autopsy findings available prior to complation of cause of death? 1☐ Yas 2☒ No

25. Was casa rafarred to medical examinar? 1☐ Yas 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accidant 3☐ Suicide 4☐ Homicida 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowledga, death occurred at the time, date and place, and due to tha causa(s) and mannar as stated. 2☐ **Medical Examinar:** On tha basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to tha causa(s) and mannar stated.

29b. Signature and title of certifier: Kanthotla

29c. Licansa number: P12090

29d. Date signed *(Month, Day, Year)*: AUGUST 13/1999

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): SUMABALA KASI BHOTLA, 3001, S. HANOVER ST. BALTIMORE MD 21225

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 17 1999

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

99-4646-510
DDG

FLORENCE BARBER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 25647

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Florence M. Barber
2. Date of Death Month / Day / Year: AUGUST 11, 1999
3. Time of Death: 0215 AM

4a. Facility Name *(If not institution, give street and number)*: UNION MEMORIAL HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: NA

Funeral Director

5. Social Security Number: 212-48-1754
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 54 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 10-23-44
9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: ☒ Yes 2☐ No
10e. Street and Number: 3803 Belair Road
10f. Zip Code: 21213
10g. Citizen of What Country?: USA

11. Marital Status: ☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*
Elementary/Secondary (0-12): 11th Grade
College (1-4or 5+): NA
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Disable
16b. Kind of Business/Industry: unemployed

17. Father's Name *(First, Middle, Last)*: Raymond J. Barber
18. Mother's Name *(First, Middle, Maiden Surname)*: Roseanna Curtis

19a. Informant's Name/Relationship *(Type, Print)*: Towanna Decator
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3803 Belair Road Baltimore, Maryland 21213

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: New Cathedral Cem. Date: 08-16-99
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Baltimore, Maryland 21202
WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Atherosclerotic Cardiovascular disease
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Chronic obstructive pulmonary disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? INSPECTION 1☐ Yes ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes ☒ No

25. Was case referred to medical examiner? ☒ Yes 2☐ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician**: To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] M.D.
29c. License number: O.C.M.E.
29d. Date signed *(Month, Day, Year)*: AUGUST 13, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 17 1999
32. Registrar's Signature: [signature]

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

ORIGINAL

11:13 AM

Albert Barthlow 8/10/99

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25648

AMENDED ITEM # 19a PER FH G774 8/17/99 AH

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
ALBERT STANLEY BARTHLOW	08	10	99	11:13 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
GILCHRIST	TOWSON	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	Days	If Under 24 Hrs. Hours	Min.	8. Date of Birth (Month, Day, Yeer)	9. Birthplace (State or Foreign Country)
236 28 5459	1☒ M 2☐ F	74 Yrs.					03 18 25	WV

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	BALTIMORE	DUNDALK	1☐ Yes 2☒ No

10e. Street end Number	10f. Zip Code	10g. Citizen of What Country?
7725 MEATH RD	21222	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☐ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8TH	N/A	MAINTENANCE	GOLDEN RING MALL

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Malden Surname)
RAYMOND BARTHLOW	LYDIA STANLEY

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)
AGNES CATROW BARTHLOW /WIFE	7725 MEATH ROAD DUNDALK MD 21222

20a. Method of Disposition	20b. Place of Disposition (Neme of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	BALTIMORE WASHINGTON	081399	LAUREL MD

21. Signature of Funeral Servica Licansee	22. Name and Address of Facility
Bren Ann Burton	ROSEDALE FUNERAL CHAPEL MARTINSBURG WV 25401

To Be Completed by Funeral Director

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset end Death
Immediate Cause (Final disease or condition resulting in death)	e. Lung Cancer	4 months
	Due to (or es a consequence of):	
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Due lo (or as a consequence of):	
	c. Due to (or es a consequenca of):	
	d.	

Part II. **Other significant condtions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown	1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Piece of Death (Check only one)	
1☐ Yes 2☒ No	Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Manner of Death	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)
1☒ **Certifying Phyeician:** To the best of my knowledge, deeth occurred at the time, date end piece, end due to the cause(s) and manner as steted.
2☐ **Medical Examiner:** On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
J. Anthony Riley, MD	D25205	August 10, 1999

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)
W.A. Riley GBMC 6701 N. Charles St. Balto. md 21204

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
AUG 17 1999	G. Sparks

DHMH 16 Rev 6/95

AH 14

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25649

Certificate of Death

Reg. No.

Baker, Elizabeth

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Elizabeth Irene Baker
2. Date of Death — Month: August Day: 15, Year: 1999
3. Time of Death: 12:15a.m.
4e. Facility Name (If not institution, give street and number): Stella Maris - Mercy
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-26-9203
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 65 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 26, 1933
9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 124 W. Franklin Street Apt. 806
10f. Zip Code: 21201
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): — College (1-4or 5+): 2
16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Nurse
16b. Kind of Business/Industry: University of Maryland Hospital

17. Father's Name (First, Middle, Last): John D. Hunter
18. Mother's Name (First, Middle, Maiden Surname): Ailene

19e. Informant's Name/Relationship (Type, Print): Daughter Mischele E. Baker
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 236 Douglas Ct. Balto. MD. 21231

20e. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory
Date: Aug. 16
20c. Location - City or Town, State: Balto. MD.

21. Signature of Funeral Service Licensee: ▶ Robert E. Nutter
22. Name and Address of Facility: Nutter Funeral Homes, Inc 2501 Gwynns Falls Pkwy Balto. MD. 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Metastatic Breast Cancer
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: End Stage Renal Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one) — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Dr Thy M
29c. License number: D40854
29d. Date signed (Month, Day, Year): 8/18/99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David Rusebush, MD 301 St Paul Pl Baltimore, MD 21202

State Registrar

31. Date filed (Month, Day, Year): AUG 17 1999
32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

AAG

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25650

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician /Medical Examiner — **To Be Completed by Funeral Director**

1. Decedent's Name (First, Middle, Last): JEROME BAILEY
2. Date of Death: Month 8 Day 12 Year 99
3. Time of Death: 1745
4a. Facility Name (If not institution, give street and number): UNIVERSITY OF MARYLAND
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219 30 2445
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 63 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 5/27/36
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 202 N. FREMONT AVE #4
10f. Zip Code: 21201
10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): WELDER/BURNER
16b. Kind of Business/Industry: SPARROWS POINT

17. Father's Name (First, Middle, Last): GEORGE S. BAILEY, SR.
18. Mother's Name (First, Middle, Maiden Surname): FANNIE E. JOHNSON

19a. Informant's Name/Relationship (Type, Print): LORRAINE LEDBETTER / SISTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 817 W. SARATOGA STREET #5 BALTIMORE, MD 21201

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): WOODLAWN CEMETERY
Date: 8/19/99
20c. Location - City or Town, State: WOODLAWN, MD

21. Signature of Funeral Service Licensee: ▶ Jerry Harris
22. Name and Address of Facility: CHATHAM - HARRIS F.H. 5240 KENSINGTON ROAD BALTIMORE, MD 21215

Physician /Medical Examiner — **Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CORONARY ARTERY DISEASE
Due to (or as a consequence of):
b. TOBACCO SMOKING
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c. ELEVATED CHOLESTEROL
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ DePriest White Jr
29c. License number: D33913
29d. Date signed (Month, Day, Year): 8/12/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DePriest White Jr

State Registrar

31. Date filed (Month, Day, Year): AUG 17 1999
32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25651

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Beatrice Bennett

2. Date of Death Month Day Year: Aug. 10, 1999

3. Time of Death: 9 30 p

4a Facility Name (If not institution, give street and number): Long Green Nursing Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-24-5770

6. Sex: 1☐ M 2☒ F

7. Age (If yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): FEB. 19, 1918

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10e. State: Maryland

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 3739 MANCHESTER AVE

10f. Zip Code: 21215

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Bieck, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grede completed): Elementery/Secondary (0-12): 10th grade | College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Cafeteria Worker

16b. Kind of Business/Industry: BALTIMORE City

17. Father's Name (First, Middle, Last): CHARLES ANDERSON

18. Mother's Name (First, Middle, Meiden Surneme): LAURA POTTS

19e. Informent's Neme/Reietionship (Type, Print): Betty Brown / Daughter

19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 5245 Cordelia Ave Baltimore Md 21215

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Druid Ridge Cemetery

Dete: 8-16-99

20c. Location - City or Town, State: Pikesville, Maryland

21. Signeture of Funerel Service Licensee: Gary Harris

22. Name end Address of Facility: CHATMAN-HARRIS F.H. 5240 Reisterstown Road Baltimore, Maryland 21215

Physician /Medical Examiner

23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one ceuse on eech line.

Approximete Interval Between Onset end Deeth

Immediate Ceuse (Final diseese or condition resulting in death): a. Congestive Heart Failure — years

Due to (or es a consequence of): b. Cardiomyopaty — years

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Lest

Due to (or es e consequence of): c.

Due to (or es e consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

Chronic Renal Failure

Mitral Regurgitation

Ischemic Bowel

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings aveilebie prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medicel exeminer? 1☐ Yes 2☒ No

26. Piece of Deeth (Check only one) Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Sulcide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the cause(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner steted.

29b. Signeture and title of certifier

29c. License number: D17118

29d. Date signed (Month, Day, Year): 8/11/99

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Paul Schwartz M.D. 115 E. Melrose Ave 21212

State Registrar

31. Dete filed (Month, Day, Yeer): AUG 17 1999

32. Registrer's Signeture: D. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25652

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARJORIE B. BARTOLOMEO

2. Date of Death: Month August Day 16 Year 1999

3. Time of Death: 0407

4a. Facility Name (If not institution, give street and number): Fallston General Hospital

4b. City, Town, or Location of Death: Fallston

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 213-48-5795

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 93 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 26, 1906

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Bel Air

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 457 Amelanchier Court

10f. Zip Code: 21015

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Clement Decker

18. Mother's Name (First, Middle, Maiden Surname): Nannie Driver

19a. Informant's Name/Relationship (Type, Print): G. Joseph Bartolomeo (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 457 Amelanchier Court, Bel Air, MD. 21015

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Most Holy Redeemer Cem.

Date: 8/19/99

20c. Location - City or Town, Stete: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, MD. 21014

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

8/16/99 0407

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. cardiogenic shock — <1d

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
altzheme's disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

MARJORIE Bartolomeo

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in *my* opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ David S. Dunn

29c. License number: D 32237

29d. Date signed (Month, Day, Year): August 16, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID S. DUNN 615 W. MacPhail

State Registrar

31. Date filed (Month, Day, Year): AUG 17 1999

32. Registrar's Signature: ▶ Geneva G. Jones

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25653

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Theodore R. Birk
2. Date of Death — Month: August Day: 15, Year: 1999
3. Time of Death: 7:50 A.M.
4a. Facility Name *(If not institution, give street and number)*: Genesis Eldercare
4b. City, Town, or Location of Death: Severna Park
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 219-22-7249
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 72 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: April 22 1927
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Pasadena
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 38 Luke Drive
10f. Zip Code: 21122
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)* — Elementary/Secondary (0-12): 12 — College (1-4or 5+):
18a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Carpenter
16b. Kind of Business/Industry: Local Union

17. Father's Name *(First, Middle, Last)*: Alexander Birk
18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Hallikas

19a. Informant's Name/Relationship *(Type, Print)*: Freeda Birk (wife)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 38 Luke Drive, Pasadena, Maryland 21122

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Glen Haven Cemetery — Date: August 18,1999
20c. Location - City or Town, State: Glen Burnie, Md.

21. Signature of Funeral Service Licensee ▶ [signature]
22. Name and Address of Facility: Stallings Funeral Hpme, P.A. 3111 Mountain Road, Pasadena, Md. 21122

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D38958
29d. Date signed *(Month, Day, Year)*: 8/16/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Daljeet Singh Sidhu 1413 Annapolis Road #106 Odenton MD 21113

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 17 1999
32. Registrar's Signature: [signature] B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25654

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William Anthony Bacon
2. Date of Death (Month, Day, Year): August 14, 1999
3. Time of Death: 2:10 PM
4a. Facility Name (If not institution, give street and number): Gilchrist Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore Co.

Funeral Director

5. Social Security Number: 217-18-6335
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): January 20, 1924
9. Birthplace (State or Foreign Country): Baltimore, Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore Co.
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1515 Clearwood Road
10f. Zip Code: 21234-5050
10g. Citizen of What Country?: United States of America

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: W.W.II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Pressman
16b. Kind of Business/Industry: Baltimore Sun Paper

17. Father's Name (First, Middle, Last): Joseph Edward Bacon
18. Mother's Name (First, Middle, Maiden Surname): Ellen Maria Murphy

19a. Informant's Name/Relationship (Type, Print): Mrs. Lois May(nee Dashiells)Bacon(Wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1515 Clearwood Road Baltimore, Maryland 21234-5050

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Dulaney Valley Memorial Gardens
Date: 8/18/1999
20c. Location - City or Town, State: Timonium, Maryland

21. Signature of Funeral Service Licensee: Jeffrey L. Gair
Jeffrey L. Gair
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204-2515

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Chronic obstructive lung disease — years
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
is chronic cardio myopathy

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) Hospice
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: W. Anthony Riley, MD
29c. License number: D25205
29d. Date signed (Month, Day, Year): August 15, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W. A. Riley GBMC 6701 N. Charles St. Balto. md 21204

State Registrar

31. Date filed (Month, Day, Year): AUG 17 1999
32. Registrar's Signature: Linda B. Sparks

DHMH 16 Rev 6/95

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

8/14/99 2:19pm

Bacon, William A

qtl

91

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25655

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Janet Brown

2. Date of Death (Month, Day, Year): AUG 14, 1999

3. Time of Death: 2:30 AM

4a. Facility Name (If not institution, give street and number): 2589 Conway Road

4b. City, Town, or Location of Death: Odenton

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 220-70-5113

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 41 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): SEP 18, 1957

9. Birthplace (State or Foreign Country): District of Columbia

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Odenton

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2589 Conway Road

10f. Zip Code: 21113

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Driver

16b. Kind of Business/Industry: Garbage Company

17. Father's Name (First, Middle, Last): Ralph Randolph Willet

18. Mother's Name (First, Middle, Maiden Surname): Anna Moulden

19a. Informant's Name/Relationship (Type, Print): Clarence G. Brown/husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2589 Conway Rd. Odenton, MD 21113

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory, Inc. Date: 08/16/99

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Edward A. Gregorchik

22. Name and Address of Facility: Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) e. Multiple Sclerosis — 10 yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: R. Sukow

29c. License number: D18480

29d. Date signed (Month, Day, Year): 8/16/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): RONALD C. SROKA, MD. 1684 VILLAGE GREEN CROFTON MD 21114

State Registrar

31. Date filed (Month, Day, Year): AUG 17 1999

32. Registrar's Signature: D. Spates

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

JOSEPHINE BIERAU

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 25656

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Josephine Bierau

2. Date of Death Month: AUGUST Day: 16 Year: 1999

3. Time of Death: 9:20 AM

4e Facility Name (If not institution, give street and number): Stella Maris Hospice @ Mercy Med. Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-07-2195

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 93 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): OCT 21, 1905

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. Stete: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 524 N. Charles Street

10f. Zip Code: 21201

10g. Citizen of Whet Country?: USA

11. Meritel Status: 1☐ Never Merried 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- tf Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Rece - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Bookkeeper

16b. Kind of Business/Industry: Machine Shop

17. Fether's Neme (First, Middle, Last): John Schaffer

18. Mother's Neme (First, Middle, Meiden Surneme): Tina Phillips

19e. Informent's Neme/Reletionship (Type, Print): Walter W. Schaffer/nephew

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 831 Cedar Grove Rd. Baltimore, MD 21221

20e. Method of Disposition: 1☐ Buriel 2☒ Cremation 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Metro Crematory, Inc. Dete: 08/17/99

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Edward A. Gregorchik

22. Neme and Address of Feclity: Cremation Society of MD., Inc. 299 Frederick Rd. Baltimore, MD 21228

Physician /Medical Examiner

23a. Pert1. Enter the diseese or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heert feilure. List only one ceuse on eech line. (Approximete Interval Between Onset end Deeth)

Immediate Ceuse (Finel diseese or condition resulting in deeth): e. CONGESTIVE HEART FAILURE

Due to (or es e consequence of):

Sequentielly list conditions, if eny, leeding to Immediete ceuse. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in deeth) Lest:

b. ACUTE CVA

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: ATRIAL FIBRILLATION; ACUTE THROMBOEMBOLISM

23b. Dtd tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings eveilable prior to completion of cause of death? 1☐ Yes 2☑ No

25. Wes case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Deeth (Check only one): Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) STELLA MARIS ATMERCY HOSPICE

27. Menner of Death: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Yeer) | 28b. Time of Injury M | 28c. Injury et Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify) | 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the ceuse(s) and manner as stated. 2☐ **Medtcal Examiner:** On the basis of exemination end/or investigetion, in my opinion, deeth occurred et the time, dete end place, and due to the cause(s) end menner stated.

29b. Signature and title of certifier: Francis X. Strain, III, MD

29c. License number: D44715

29d. Dete signed (Month, Dey, Year): 8.16.99

30. Neme and address of person who completed ceuse of deeth (Item 23e) (Type, Print): FRANCIS X. STRAIN, III, MD 301 ST PAUL #907 BALT MD 21202

State Registrar

31. Dete filed (Month, Dey, Year): AUG 17 1999

32. Registrer's Signature: D. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit case.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25657

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: WILLIAM RAYMOND CROMWELL

2. Date of Death Month: AUG. Day: 14 Year: 1999

3. Time of Death: 255AM

4a. Facility Name *(If not institution, give street and number)*: GOOD SAMARITAN HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: NA

Funeral Director

5. Social Security Number: 212-32-7689

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 65 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 12-13-33

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. Stete: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 512 Radnor Avenue

10f. Zip Code: 21212

10g. Citizen of Whet Country?: USA

11. Meritel Status: 1 [ ] Never Merried 2 [X] Married 3 [ ] Widowed 4 [ ] Divorcad

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): NA / College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Housekeeper

16b. Kind of Business/Industry: Broadway Services

17. Father's Name *(First, Middle, Last)*: Edward O. Cromwell

18. Mother's Name *(First, Middle, Meiden Sumeme)*: Annabelle Perry

19a. Informant's Name/Relationship *(Type, Print)*: Melron McCray

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 1904 Crestview Road Baltimore, Maryland 21239

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removel from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Placa ot Disposition *(Neme of cemetery, cremetory or other place)*: Garrison Forest VA Cem. Date: 08-19-99

20c. Location - City or Town, State: MD Owings Mills,

21. Signature of Funerel Service Licensee: [signature]

22. Name and Address of Feciility: Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heert feilure. List only one cause on eech line.

Approximate Intervel Between Onset and Death

Immediate Cause (Finel disease or condition resulting in deeth)
e. RESPIRATORY FAILURE — 5 MINUTES

Due to (or as e consequence of):
b. CARDIAC FAILURE — 5 MINUTES

Sequentielly list conditions, if any, leeding to immedeite cause. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in deeth) Lest
Due to (or as e consequence of):
c. ATHEROSCLEROTIC HEART DISEASE — 20 YEARS

Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings availeble prior to completion of cause of deeth? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] inpatient 2 [X] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Menner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, fectory, offica building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end place, end due to the ceuse(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination end/or investigetion, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated.

29b. Signature end title of certifier: [signature] Francisco A. Matheus, MD

29c. License number: D41460

29d. Date signed *(Month, Dey, Year)*: 8/14/99

30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print): FRANCISCO A. MATHEUS, MD

State Registrar

31. Dete filed *(Month, Day, Year)*: AUG 17 1999

32. Registrar's Signature: [signature] B. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

471

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25658

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): James Hugo Carter
2. Dete of Deeth — Month: August — Dey: 16 — Yeer: 1999
3. Time of Deeth: 6:55 AM
4a. Fecility Neme (If not institution, give street end number): Baltimore Rehabilitation & Extended Care
4b. City, Town, or Location of Deeth: Baltimore
4c. County of Deeth: N/A

Funeral Director

5. Social Security Number: 228-16-7802
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 77 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Yeer): 05-31-22
9. Birthplece (Stete or Foreign Country): HALIFAX, VA

Usuel Residence of Decedent

10e. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street end Number: 514 NORMANDY AVE
10f. Zip Code: 21229
10g. Citizen of Whet Country?: U.S.A.

11. Maritel Stetus: 1 [ ] Never Married 2 [X] Merried 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Rece - American Indien, Bleck, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 10 — College (1-4or 5+):
16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): MACHINE OPERATOR
16b. Kind of Business/Industry: LIGHT INDUSTRY

17. Fether's Neme (First, Middle, Last): PAUL CARTER
18. Mother's Neme (First, Middle, Maiden Surneme): UNKNOWN

19e. Informent's Neme/Relationship (Type, Print): LULA MAE CARTER, WIFE
19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code): 514 NORMANDY AVE, BALTIMORE, MD 21229

20e. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removel from State 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Piece of Disposition (Neme of cemetery, crematory or other piece): GARRISON FOREST
Dete: 8-20-99
20c. Location - City or Town, Stete: OWINGSMILLS, MD

21. Signeture of Funerel Service Licensee: Willie E. Howell Jr.
22. Neme end Address of Fecility: HOWELL FUNERAL HOME 4600 LIBERTY HGHTS AVE, BALTO. MD 21207

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

23e. Pert 1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert failure. List only one ceuse on eech line.

Approximete Intervel Between Onset and Deeth

Immediete Ceuse (Final disease or condition resulting in deeth): e. Multiinfarction Dementia — 6 months
Due to (or es e consequenca of):
Sequentieily list conditions, if eny, ieeding to immediete cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in deeth) Lest:
b.
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Pert II. **Othar significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.: Arteriosclerosis

23b. Did tobacco use contribute to the causa of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24e. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No
24b. Were eutopsy findings eveiieble prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical exeminer? 1 [ ] Yes 2 [X] No
28. Place of Deeth (Check only one) — Hospitel: 1 [ ] Inpetient 2 [ ] ER/Outpetient 3 [ ] DOA — Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Menner of Deeth: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28e. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred et the time, dete end piece, and due to the cause(s) and menner es steted. 2 [ ] **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end menner steted.

29b. Signeture end title of certifier: MD
29c. License number: D0032548
29d. Dete signed (Month, Dey, Yeer): August 16, 1999

30. Neme and address of person who completed cause of death (Item 23e) (Type, Print): PERRY L COLVIN — Baltimore VA Medical Center 10 North Greene St.

State Registrar

31. Dete filed (Month, Dey, Yeer): AUG 17 1999
32. Registrer's Signeture: Donna D. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene.
Important: If item 27 is marked other than "neturel", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

AH3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25659

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Thomas Elmer Cawley

2. Date of Death: Month August, Day 14, Year 1999

3. Time of Death: 6:08 pm

4a. Facility Name (If not institution, give street and number): 7041 Charleston Avenue

4b. City, Town, or Location of Death: North Beach

4c. County of Death: Calvert

Funeral Director

5. Social Security Number: 577-54-8407

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 59 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): Sept. 14, 1939

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: MD

10b. County: Calvert

10c. City, Town or Location: North Beach

10d. Inside City Limits: 1 [ ] Yes 2 [ ] No XX

10e. Street and Number: 7041 Charleston Avenue

10f. Zip Code: 20714

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Owner/Operator

16b. Kind of Business/Industry: Printing

17. Father's Name (First, Middle, Last): Elmer Thomas Cawley

18. Mother's Name (First, Middle, Maiden Surname): Margaret Mary Dolan

19a. Informant's Name/Relationship (Type, Print): Barbara Cawley (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7041 Charleston Avenue, North Beach, MD 20714

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Southern Memorial Gardens | Date: 08/18

20c. Location - City or Town, State: Dunkirk, Maryland

21. Signature of Funeral Service Licensee: ▶ Kenneth S Bove

22. Name and Address of Facility: Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Lung Cancer — Approximate Interval: 6 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Bruce A. Silver, MD

29c. License number: D21463

29d. Date signed (Month, Day, Year): 8-16-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BRUCE A. SILVER, MD 110 HOSPITAL DR. PRINCE FREDERICK, MD 20678

State Registrar

31. Date filed (Month, Day, Year): AUG 17 1999

32. Registrar's Signature: ▶ G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25660

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
ELOISE		CARROLL	AUGUST	12	1999	11:02p

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
UNIVERSITY OF MARYLAND MEDICAL CENTER	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	Days	If Under 24 Hrs. Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
007-73-6416	1☐ M 2☒ F	64 Yrs.					May 31, 1935	GA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	Baltimore	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2721 Edmondson Avenue	21223	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☒ Yes 2☐ No *Specify:*	*Specify:* Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Nurse's Assistant	Hospital

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Elliott Banks	Elviria Pressley

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Cynthia Carroll (Daughter)	606 W, Franklin Street, Apt.3 Baltimore, MD 21201

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Arbutus Memorial Park	Aug 18 1999	Baltimore, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Calvin L. Williams	Smith & Williams Funeral Home, P.A. 2818 East Baltimore Street Baltimore, MD

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. PNEUMONIA	2 days
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. BONE MARROW TRANSPLANT	
	Due to (or as a consequence of):	
	c. MULTIPLE MYELOMA	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒ Yes 2☐ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Lalit Verma MD	P12502	AUGUST 12 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
LALIT VERMA 22 SOUTH GREENE STREET BALTIMORE MARYLAND 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
AUG 17 1999	▶ G. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

A46

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25661

AMEND ITEM: #26 PER MD G774 8-17-99 WR.

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Mary R. Colburn

2. Dete of Deeth Month Dey Yeer: Aug. 11, 1999

3. Time of Deeth: 1:55 P.M.

4a. Facility Name *(If not institution, give street end number)*: 248 Clyde Avenue

4b. City, Town, or Location of Deeth: Lansdowne

4c. County of Deeth: Baltimore

Funeral Director

5. Social Security Number: 214-03-5390

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 85 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Day, Yeer)*: Oct. 2, 1913

9. Birthpleca *(State or Foreign Country)*: Maryland

Usual Residence of Decedant

10a. State: Md.

10b. County: Anne Arundel

10c. City, Town or Location: Pasadena

10d. Inside City Limits: 1☐ Yas 2☒ No

10e. Street end Number: 7648 Berry Drive

10f. Zip Code: 21122

10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Yaar or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.): 1☐ Yas 2☒ No *Specify:*

14. Race - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7th; Collaga (1-4or 5+): 0

16a. Decedent's Usuel Occupetion *(Give kind of work dona during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Home

17. Fether's Neme *(First, Middle, Last)*: Paul F. Newton

18. Mother's Nama *(First, Middle, Maidan Sumame)*: Lula Huttenberger

19a. Informent's Name/Reletionship *(Type, Print)*: Margaret E. Warthen (Daughter)

19b. Meiling Addrass *(Straet and Number or Rural Route Number, City or Town, Steta, Zip Code)*: 7648 Berry Drive Pasadena, Maryland 21122

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from Stata 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetary, cremetory or other place)*: Lakeview Memorial Park

Dete: 8/14/99

20c. Location - City or Town, Steta: Baltimore, Maryland

21. Signeture of Funaral Service Licensee: Kevin E. Ecker

22. Name end Address of Facility: McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications thet ceused tha daath. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heert feilura. List only one ceusa on each line.

Approximate Interval Between Onsat and Death

Immediete Ceuse (Finel diseese or condition resulting in daath) a. Colon Carcinoma — years

Dua to (or as e consaquance of):

Sequentially list conditions, if eny, leeding to immediate causa. Enter Underlying Ceuse (Diseesa or injury thet initieted evants resulting in death) Lest

b.

Due to (or es e consequance of):

c.

Dua to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobecco uee contribute to the cause of death? 1☐ Yee 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to complation of causa of deeth? 1☐ Yes 2☒ No

25. Wes cese refarrad to medical exeminer? 1☐ Yes 2☒ No

26. Plece of Daath *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☒ Othar *(Specify)* GRANDDAUGHTER'S RESIDENCE

27. Mannar of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Panding Investigation 6☐ Could not be datarmined

28a. Place of Injury - At home, farm, street, factory, office building, atc. *(Specify)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Data of Injury *(Month, Dey Yaar)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Steta)*

29a. Certifier *(Check only one)* 1☒ **Certifying Physician:** To the best of my knowladga, daath occurrad at tha time, dete end plece, end due to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to tha ceuse(s) and manner statad.

29b. Signature end title of cartifier: M O'Chaney MD

29c. Licensa number: D-40521

29d. Date signed *(Month, Dey, Year)*: August 11, 1999

30. Neme end eddrass of person who completad ceuse of deeth (Item 23e) (Type, Print): DR O'CHANEY 3350 WILKENS AVENUE SUITE 302 BALTIMORE, MD 21229

State Registrar

31. Data filad *(Month, Dey, Year)*: AUG 17 1999

32. Registrer's Signeture: Emma G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25662

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Harry F. Cromwell
2. Date of Death: Month August Day 12 Year 1999
3. Time of Death: 5:40A.M.
4a. Facility Name (If not institution, give street and number): Franklin Square Hospital Center
4b. City, Town, or Location of Death: Rosedale
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-05-5248
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 88 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 21, 1910
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 4419 MacWorth Place
10f. Zip Code: 21236
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Pattern Maker
16b. Kind of Business/Industry: Steel Company

17. Father's Name (First, Middle, Last): John E. Cromwell
18. Mother's Name (First, Middle, Maiden Surname): Mary Sylvia (Surname Unknown)

19a. Informant's Name/Relationship (Type, Print): John E. Cromwell, Sr. (son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4419 MacWorth Place, Baltimore, MD 21236

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify) Entombment
20b. Place of Disposition (Name of cemetery, crematory or other place): Dulaney Valley Mausoleum
Date: 8/16/99
20c. Location - City or Town, State: Timonium, Maryland

21. Signature of Funeral Service Licensee: Robert [illegible]
22. Name and Address of Facility: Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236

Cromwell, Harry
Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Dilated Cardiomyopathy — 2 Days

Due to (or as a consequence of):
b. Chronic Obstructive Pulmonary Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. Atrial Fibrillation

Due to (or as a consequence of):
d. Gastric Ulcer

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Jacques McConaway
29c. License number: D0055034
29d. Date signed (Month, Day, Year): 8/12/1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr Jacques Conaway 9000 Franklin Square Drive Baltimore, MD 21237

State Registrar

31. Date filed (Month, Day, Year): AUG 17 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25663

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ANNA ELIZABETH CARTER
2. Date of Death (Month, Day, Year): August 14, 1999
3. Time of Death: 8:40 p.m.
4a. Facility Name (If not institution, give street and number): 107 Meadow Road
4b. City, Town, or Location of Death: Bel Air
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 153-09-2242
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 103 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 31, 1896
9. Birthplace (State or Foreign Country): New Jersey

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Bel Air
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 107 Meadow Road
10f. Zip Code: 21014
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th grade; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Salesperson
16b. Kind of Business/Industry: Sales

17. Father's Name (First, Middle, Last): John McGrath
18. Mother's Name (First, Middle, Maiden Surname): Margaret Bannon

19a. Informant's Name/Relationship (Type, Print): Theresa Keller (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 107 Meadow Road, Bel Air, MD. 21014

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): St. Mary's Cemetery
Date: 8/19/99
20c. Location - City or Town, State: Hamilton Township, N.J.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, MD. 21014

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ASCVD

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 8☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: David S. Dunn
29c. License number: D32259
29d. Date signed (Month, Day, Year): August 16, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAN. D S. DUNN 615 W. MacPhail

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): AUG 17 1999
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25664

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FRANCES COBB
2. Date of Death: Month August Day 13 Year 1999
3. Time of Death: 0510
4a. Facility Name (If not institution, give street and number): FALLSTON GENERAL HOSPITAL
4b. City, Town, or Location of Death: FALLSTON
4c. County of Death: HARFORD

Funeral Director

5. Social Security Number: 214-14-8256
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 76 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 15 1923
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.
10b. County: Harford
10c. City, Town or Location: Belair
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 102 Seevue Court
10f. Zip Code: 21014
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Dietian
16b. Kind of Business/Industry: Food

17. Father's Name (First, Middle, Last): Walter Kowalczyk
18. Mother's Name (First, Middle, Maiden Surname): Marianna Kowalczyk

19a. Informant's Name/Relationship (Type, Print): Dolores Connelly /daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3003 Sheffield Court Fallston Md. 21049

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Holy Rosary Cemetery | Date: 8/16/99
20c. Location - City or Town, State: Baltimore Md.

21. Signature of Funeral Service Licensee: ▶ R. Terry Connelly
22. Name and Address of Facility: Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. NON SMALL CELL LUNG CANCER — 1 YEAR

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ John P. Edwards MD
29c. License number: D31775
29d. Data signed (Month, Day, Year): AUGUST 13, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOHN P. EDWARDS, MD. 2112 BELAIR ROAD FALLSTON, MARYLAND 21047

State Registrar

31. Data filed (Month, Day, Year): AUG 17 1999
32. Registrar's Signature: Bonnie G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Cobb, Frances

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25665

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY LOUISE COLLETT
2. Date of Death (Month, Day, Year): August 13, 1999
3. Time of Death: 7:50 AM
4a. Facility Name (If not institution, give street and number): Armacost Nursing Home
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 210-16-0222
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 73 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 15, 1926
9. Birthplace (State or Foreign Country): Pa.

Usual Residence of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 812 Register Ave.
10f. Zip Code: 21212
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Payroll Dept.
16b. Kind of Business/Industry: NBC

17. Father's Name (First, Middle, Last): William Collett
18. Mother's Name (First, Middle, Maiden Surname): Ida Kersetter

19a. Informant's Name/Relationship (Type, Print): Mrs. Lorraine Daddezio/sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4 Comer Ct. #201 Timonium, Md. 21093

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Hilltop Service Corp. | Date: 8/16/99
20c. Location - City or Town, State: Towson, Md.

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Acute Myocardial Infarction.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Henri Nammour M.D.
29c. License number: D35890
29d. Date signed (Month, Day, Year): 08,13,99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Henri Nammour, M.D. 827 Linden Ave. Baltimore, Md. 21201

State Registrar

31. Date filed (Month, Day, Year): AUG 17 1999
32. Registrar's Signature: ▶ [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25666

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Angelus Longhofer Cozart

2. Date of Death (Month, Day, Year): AUGUST 13, 1999

3. Time of Death: 10:30 AM

4a. Facility Name (If not institution, give street and number): Gilchrist Center

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 403-80-6998

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 46 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): OCT 27, 1952

9. Birthplace (State or Foreign Country): Kentucky

Usual Residence of Decedent

10a. State: DE

10b. County: New Castle

10c. City, Town or Location: Hockessin

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 122 Dewberry Drive

10f. Zip Code: 19707

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Domestic

17. Father's Name (First, Middle, Last): Roy Longhofer

18. Mother's Name (First, Middle, Maiden Surname): Estalyn Clark

19a. Informant's Name/Relationship (Type, Print): James Edgar Cozart/husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 122 Dewberry Drive Hockessin, Delaware19707

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory, Inc. Date: 08/14/99

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Edward A. Gregorchik

22. Name and Address of Facility: Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. Enter only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. MELANOMA — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: W. A. Riley, MD

29c. License number: D25205

29d. Date signed (Month, Day, Year): August 13, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W. A. Riley [illegible] 6701 N. Charles St., Balto. md 21204

State Registrar

31. Date filed (Month, Day, Year): AUG 17 1999

32. Registrar's Signature: B. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Angelus Cozart August 13 1999 @ 1030AM

A-10

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25667

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Raymond B. Coleman

2. Date of Death (Month, Day, Year): August 14 1999

3. Time of Death: 10:55 PM

4a. Facility Name (If not institution, give street and number): Franklin Woods Nursing Home

4b. City, Town, or Location of Death: Rosedale

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 284-20-3457

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 69 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug 3, 1930

9. Birthplace (State or Foreign Country): Ohio

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Dundalk

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 1411 Stengel Ave

10f. Zip Code: 21222

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Foreman

16b. Kind of Business/Industry: Steel

17. Father's Name (First, Middle, Last): Floyd Coleman

18. Mother's Name (First, Middle, Maiden Surname): Ora Donaldson

19a. Informant's Name/Relationship (Type, Print): Jacqueline Coleman /wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1411 Stengel Ave Baltimore, MD 21222

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Holy Rosary Cemetery

Date: Aug 18 1999

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Anthony C. Connelly

22. Name and Address of Facility: Connelly Funeral Home of Dundalk 7110 Sollers Point Rd 21222

Physician /Medical Examiner

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic non small cell lung cancer — 15 months

Due to (or as a consequence of):

b. Emphysema — 2 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: S. Sivasaliam MD

29c. License number: D45530

29d. Date signed (Month, Day, Year): 8-15-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): S. Sivasaliam, M.D. 6830 Hospital Drive Baltimore, MD 21237

State Registrar

31. Date filed (Month, Day, Year): AUG 17 1999

32. Registrar's Signature: Lynn D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

AH10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25668

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Blanche Louise Dye
2. Date of Death: Month August, Day 13, Year 1999
3. Time of Death: 10:10 am
4a. Facility Name (If not institution, give street and number): Millennium Health and Rehabilitation Center
4b. City, Town, or Location of Death: Edgewater
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 218-03-9980
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Yaar: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): July 16, 1918
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Edgewater
10d. Inside City Limits: 1☐ Yas 2☒ No
10e. Street and Number: 245 Monroe Avenue
10f. Zip Coda: 21037
10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 1☐ Yas 2☒ No Specify:
14. Raca - Amarican Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highast grada completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired): Credit Manager
16b. Kind of Businass/Industry: Oil Company

17. Fathar's Nama (First, Middla, Last): Dyson H. Welch
18. Mothar's Nama (First, Middle, Maiden Surnama): Susan Emily Della

19a. Informant's Name/Ralationship (Type, Print): Wilson J. Dye III (Son)
19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 1302 27th Street Court, NW, Gig Harbor, WA 98335

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stata 4☐ Donation 5☐ Othar (Specify)
20b. Place of Disposition (Nama of camatary, cramatory or othar placa): Lakemont Cemetery
Date: 08/16
20c. Location - City or Town, Stata: Davidsonville, MD

21. Signature of Funaral Service Licensee: Kimberly S. Bore
22. Nama and Address of Facility: Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not entar tha moda of dying, such es cardiac or respiratory arrest, shock, or haart failura. List only one causa on aach lina.

Approximate Intarval Batwaen Onsat and Death: MORE THAN 1 YEAR

Immediate Ceusa (Final diseasa or condition rasulting in death):
a. AORTIC STENOSIS

Dua to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Cause (Disease or injury thet initiated avents rasulting in death) Last
b. ATHEROSCLEROSIS

Dua to (or as a consequence of):
c.

Due to (or es e consequance of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying cause givan in Part I.
CONGESTIVE HEART FAILURE
RENAL INSUFFICIENCY

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yas 2☐ No

25. Wes casa referred to medical axaminar? 1☐ Yas 2☒ No

26. Placa of Death (Check only ona): Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Mannar of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending investigation 6☐ Could not be determined

28a. Data of Injury (Month, Day Year)
28b. Tima of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, atreet, factory, offica building, atc. (Specify)
28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifiar (Check only one): 1☑ **Certifying Physician**: To tha best of my knowledge, deeth occurred at tha tima, data and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On tha basis of examination and/or investigation, in my opinion, daath occurred at tha tima, data and placa, and dua to the causa(s) and mannar statad.

29b. Signeture and title of certifiar: Gyan Chand Sura
29c. Licanse number: D 50653
29d. Data signed (Month, Day, Year): 8-13-1999

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): GYAN CHAND SURANA 5851 Dealechurchton Road, Deale MD 20751

State Registrar

31. Data filed (Month, Day, Year): AUG 17 1999
32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25669

Donaho, Katherine

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month / Day / Year)	3. Time of Death
Katherine G. Donaho	AUGUST 15 1999	2:30 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
NORTH ARUNDEL HOSPITAL	GLEN BURNIE	ANNE ARUNDEL

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
578-40-3886	1☐ M 2☒ F	68 Yrs.			Oct. 26, 1930	Washington, DC

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Anne Arundel	Gambrills	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2276 Four Seasons Drive	21054	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4 or 5+)		
12		Secretary	Civil Service

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Robert Edward Dailey	Marie Veronica Moeller

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Donna Beltowski (Daughter)	131 Glenwood Drive, Hubert, NC 28539

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Maryland Veterans Cem.	08/19	Cheltenham, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Michele P. Lutton	Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Stroke	three days
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Cardiomyopathy

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ MD	D48006	August 15, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
KOFI BONITEY, 301 Hosp. Dr, Glen Burnie, MD 21061

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
AUG 17 1999	Virginia G. Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25670

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Cornelius C. Devese
2. Date of Death: Month August Day 12 Year 1999
3. Time of Death: 4:18 Am
4a. Facility Name (If not institution, give street and number): Hopkins Bayview Medical Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-12-0805
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 16, 1916
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1904 Jefferson Road
10f. Zip Code: 21222
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9th grade | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mechanic
16b. Kind of Business/Industry: Automotive

17. Father's Name (First, Middle, Last): William DeVese
18. Mother's Name (First, Middle, Maiden Surname): Mame (Unknown)

19a. Informant's Name/Relationship (Type, Print): William M. Poulsen Jr. (Ex-stepson)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1005 Brookwood Drive, Joppa, MD. 21085

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Green Mount Crematory
Date: 8/13/99
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, MD. 21014

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Stroke
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] MD
29c. License number: 20327
29d. Date signed (Month, Day, Year): August 12, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Tyler Reimschisel 4940 Eastern Av. Baltimore, MD 21224

State Registrar

31. Date filed (Month, Day, Year): AUG 17 1999
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25671

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DORIS DEMBECK

2. Date of Death (Month, Day, Year): AUGUST 14 1999

3. Time of Death: 1343

4a. Facility Name (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE CITY

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-24-9436

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 69 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): Sept. 5,1929

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Dundalk

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 883 Mildred Avenue

10f. Zip Code: 21222

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elamentary/Secondary (0-12): 10 Years; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Joseph Bravato

18. Mother's Name (First, Middle, Maiden Surname): Margaret Rose

19a. Intormant's Name/Relationship (Type, Print): Mark Dembeck / Son

19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1 Elkhart Court Rosedale, Maryland 21237

20a. Method ot Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place ot Disposition (Name of cemetery, crematory or other place): Sacred Ht. of Mary Cem.

Date: 8/18/1999

20c. Location - City or Town, State: Dundalk, Maryland

21. Signature of Funeral Service Licensee: Chas W. Tuck

22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one causa on aach lina.

Approximata Interval Between Onset and Death

Immediata Cause (Final disease or condition resulting in daath)

a. Left cerebellar pontine angle tumor — three weeks

Dua to (or as a consequence of):

Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Dua to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Were autopsy tindings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case raferred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only ona): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Mannar ot Death: 1☒ Natural 2☐ Accidant 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be datermined

28a. Date ot Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best ot my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis ot axamination and/or investigation, in my opinion, death occurred at tha time, data and place, and due to the cause(s) and manner stated.

29b. Signatura and title of certifier: MD

29c. License number: RES-000

29d. Date signed (Month, Day, Year): August 14, 1999

30. Name and address ot person who completed causa ot daath (Item 23a) (Type, Print): IRA GARONZIK 600 North Wolfe Street

State Registrar

31. Date tiled (Month, Day, Year): AUG 17 1999

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rav 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25672

Physician /Medical Examiner

1. Decedent's Nema *(First, Middle, Last)*: John Evans
2. Date of Deeth: Month AUG Day 14 Yaer 1999
3. Time of Deeth: 0725A
4a. Facility Nama *(If not institution, give street end number)*: Lorien Nursing Home
4b. City, Town, or Location of Death: Baltimore
4c. County of Deeth:

Funeral Director

5. Social Sacurity Number: 216 32 9520
6. Sex: 1☒M 2☐F
7. Age *(In yrs. lest birthday)*: 64 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Yeer)*: Feb. 3, 1935
9. Birthpiaca *(State or Foreign Country)*: Maryland

Usual Residenca of Decedent

10a. Stete: Maryland
10b. County: Baltimore
10c. City, Town or Location: Essex
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street end Number: 951 Martin Rd.
10f. Zip Code: 21221
10g. Citizen of Whet Country?: USA

11. Maritel Stetus: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorcad
12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Yeer or Detes: 1957
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Spacify:*
14. Race - Amarican Indian, Black, White, etc. *Specify:* White

15. Decadent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Maintenance Technician
16b. Kind of Business/Industry: Steel Co.

17. Father's Neme *(First, Middle, Last)*: John W. Evans Sr.
18. Mothar's Name *(First, Middle, Maiden Sumame)*: Almira Adams

19e. Informant's Neme/Raletionship *(Type, Print)*: Kathleen Evans (Wife)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 951 Martin Rd. Baltimore, Md. 21221

20e. Method of Disposition: 1☒Buriel 2☐Cremation 3☐Ramoval from State 4☐Donetion 5☐Other *(Specify)*
20b. Pleca of Disposition *(Neme of cametary, cremetory or other place)*: Holly Hill Mem. Gardens — Dete: 8/17/1999
20c. Location - City or Town, Stete: Baltimore, Md.

21. Signature of Funerel Service Licensee: John W. Burkowske
22. Name end Address of Fecility: Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221

Physician /Medical Examiner

23a. Part 1. Enter the disaasa, or complicetions that caused the deeth. Do not enter the moda of dying, such es cardiec or respiretory errest, shock, or haart feilure. List only one cause on eech line. — Approximete Interval Between Onset and Death

Immediete Causa (Finai diseese or condition resulting in death): e. Metastatic Lung Cancer — 2 Months
Due to (or es a consequenca of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in deeth) Last:
b. Due to (or es e consequence of):
c. Due to (or es a consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Polymyositis; Respiratory Failure; Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☒Probably 4☐Unknown

24a. Wes en eutopsy performed? 1☐Yes 2☒No
24b. Were eutopsy findings evaliebla prior to completion of cause of deeth? 1☐Yes 2☐No

25. Wes case referred to medical examiner? 1☐Yes 2☒No
26. Place of Deeth *(Check only one)*: Hospitel: 1☐inpatient 2☐ER/Outpetient 3☐DOA — Other: 4☒Nursing Homa 5☐Residence 6☐Other *(Specify)*

27. Menner of Deeth: 1☒Naturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury *(Month, Dey Year)*
28b. Time of injury M
28c. Injury et Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician**: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) end menner es stated. 2☐**Medical Examiner**: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) end menner stated.

29b. Signature end title of certifier: Sanjay P. Shah, MD
29c. Licansa number: D0052940
29d. Date signed *(Month, Day, Year)*: AUG 16 1999

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print): SANJAY P. SHAH, MD 10805 Hickory Ridge Rd #210 Columbia MD 21044

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: AUG 17 1999
32. Registrar's Signeture: B. Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funerel director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25673

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOSEPHINE MAY SMITH ECKENRODE

2. Date of Death (Month, Day, Year): August 12, 1999

3. Time of Death: 11:55 AM

4a. Facility Name (If not institution, give street and number): Manor Care Nursing Center, Towson

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore County

Funeral Director

5. Social Security Number: 217-18-0130

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 94 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb 10, 1905

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore County

10c. City, Town or Location: Towson

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 804 Providence Road

10f. Zip Code: 21286

10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 th | College (1-4or 5+):

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Residence

17. Father's Name (First, Middle, Last): John Brooke Smith

18. Mother's Name (First, Middle, Maiden Surname): Mary Alice Peckocheck

19a. Informant's Name/Relationship (Type, Print): Elizabeth E. Rickenback (Daughtr)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 804 Providence Road, Towson, Maryland 21286

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): New Cathedral Cemetery | Date: 8/16/99

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Martin D. Lawson

22. Name and Address of Facility: Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road, Baltimore, Maryland 21212

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Chronic obstructive pulmonary disease — >2 years

Due to (or as a consequence of):

b. Pneumonia — 2 wks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Anemia

Due to (or as a consequence of):

d. peripheral vascular disease

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D42736

29d. Date signed (Month, Day, Year): 8-13-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ayman F. Akkad, M.D. 7600 Osler Dr. Towson, MD 21204

State Registrar

31. Date filed (Month, Day, Year): AUG 17 1999

32. Registrar's Signature: Linda G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25674

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James Eddinger
2. Date of Death (Month, Day, Year): August 15 1999
3. Time of Death: 12:50PM
4a. Facility Name (If not institution, give street and number): SINAI HOSPITAL OF BALTIMORE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 206-28-2352
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 63 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): November 17, 1935
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 3016 Romaric Ct.
10f. Zip Code: 21209
10g. Citizen of What Country? United States

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1955-58
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): driver/chauffeur
16b. Kind of Business/Industry: cab company

17. Father's Name (First, Middle, Last): Joseph B. Eddinger
18. Mother's Name (First, Middle, Maiden Surname): Margaret M. Ward

19a. Informant's Name/Relationship (Type, Print): John W. Eddinger/brother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 323 Tunbridge Rd. Baltimore, MD 21212

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Holy Savior Cemetery
Date: 8/19/99
20c. Location - City or Town, State: Bethlehem, Pennsylvania

21. Signature of Funeral Service Licensee: John O. Mitchell III
22. Name and Address of Facility: Mitchell-Wiedefeld Funeral Home, Inc 6500 York Rd. Baltimore, MD 21212

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. HYPOXIA
Due to (or as a consequence of):
b. MYOCARDIAL INFARCT
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c. CEREBROVASCULAR ACCIDENT
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: P13214
29d. Date signed (Month, Day, Year): August 15, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Chris Ha, Sinai Hospital, 2401 W. Belvedere Ave, Baltimore, MD 21215

State Registrar

31. Date filed (Month, Day, Year): AUG 17 1999
32. Registrar's Signature: Jenna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25675

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: FR. JAMES ELLIOTT

2. Date of Death (Month, Day, Year): August 10 1999

3. Time of Death: 8:30 pm

4a. Facility Name *(If not institution, give street and number)*: STELLA MARIS

4b. City, Town, or Location of Death: TIMONIUM

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 098-42-4638

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 71 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 7/10/28

9. Birthplace *(State or Foreign Country)*: NEW YORK

Usual Residence of Decedent

10a. State: MD

10b. County: HOWARD

10c. City, Town or Location: ELLICOTT CITY

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 12300 FOLLY QUARTER RD.

10f. Zip Code: 21042

10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 5+

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: FRANCISCAN PRIEST

16b. Kind of Business/Industry: CHURCH

17. Father's Name *(First, Middle, Last)*: unknown

18. Mother's Name *(First, Middle, Maiden Surname)*: IRENE ELLIOTT

19a. Informant's Name/Relationship *(Type, Print)*: FR. MARK CURESKY

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 12300 FOLLY QUARTER RD. ELLICOTT CITY, MD 21042

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: ST. STANISLAUS CEME,

Date: 8/13/99

20c. Location - City or Town, State: BALTO., MD.

21. Signature of Funeral Service Licensee: Charles Kaczorowski

22. Name and Address of Facility: KACZOROWSKI FUNERAL HOME P.A. 1201 DUNDALK AVE. BALTO., MD. 21222

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Acute myocardial infarction

Due to (or as a consequence of): Coronary Artery Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

1/12 Gift: Mattress

Lymphoma Ca.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D 15504

29d. Date signed *(Month, Day, Year)*: 8-11-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Eddie Nakhuda, M.D. 2300 Dulaney Valley Rd Timonium Md 21093

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 17 1999

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified as soon.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME: ELLIOTT, JAMES

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25676

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LOUIS B FELL
2. Date of Death: Month August Day 13 Year 1999
3. Time of Death: 6:30 P.M.
4a. Facility Name (If not institution, give street and number): FRANKLIN SQUARE HOSPITAL CENTER
4b. City, Town, or Location of Death: Rosedale
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 215-18-3818
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 76 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 22 1923
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Essex
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 18 South Essex Ave.
10f. Zip Code: 21221
10g. Citizen of What Country: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9th | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Engineer
16b. Kind of Business/Industry: Railroad

17. Father's Name (First, Middle, Last): Joseph Jerome Fell
18. Mother's Name (First, Middle, Maiden Surname): Grace Miller

19a. Informant's Name/Relationship (Type, Print): Barbara Fell / wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 18 South Essex Ave. Baltimore Md. 21221

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Holly Hill Cemetery Date: 8/18/99
20c. Location - City or Town, State: Baltimore Md.

21. Signature of Funeral Service Licensee: ▶ R. Terry Connelly
22. Name and Address of Facility: Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Stunned Myocardium — 24 Hours
Due to (or as a consequence of):
b. STATUS POST ABDOMINAL AORTIC ANEURYSM
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶
29c. License number: RD 196592
29d. Date signed (Month, Day, Year): August 13, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. HUZEFA BAHRAIN 9000 FRANKLIN SQUARE DR. BALTIMORE MARYLAND 21237

State Registrar

31. Date filed (Month, Day, Year): AUG 17 1999
32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Louis Fell

Q-10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25677

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Evelyn Dorothy Fife

2. Date of Death: Month: August Day: 12 Year: 1999

3. Time of Death: 8:11 P.M.

4a. Facility Name (If not institution, give street and number): 7005 York Rd.

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 213-60-3959

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 92 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): October 27, 1906

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 7005 York Rd.

10f. Zip Code: 21212

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): school teacher

16b. Kind of Business/Industry: education

17. Father's Name (First, Middle, Last): (Unk.) Sweitzer

18. Mother's Name (First, Middle, Maiden Surname): Grace Brenneman

19a. Informant's Name/Relationship (Type, Print): Keith Straley/personal rep.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13834 Manor Glen Rd. Baldwin, MD 21013

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Christ Ev. Lutheran Ch. Cem.

Date: 8/16/99

20c. Location - City or Town, State: Shrewsbury, PA

21. Signature of Funeral Service Licensee: John D. Mitchell IV

22. Name and Address of Facility: Mitchell-Wiedefeld Funeral Home, Inc 6500 York Rd. Baldwin, MD 21212

Physician /Medical Examiner

23a. Part I. Enter the diseasa, or complications thet caused the death. Do not entar tha mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disaese or condition resulting in death)

a. Multi-infarct dementia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Timothy Herlihy, M.D.

29c. License number: D32639

29d. Date signed (Month, Day, Year): 8/13/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Timothy Herlihy, M.D. 660 Kenilworth Dr., #202 Towson, MD 21204

State Registrar

31. Date filed (Month, Day, Year): AUG 17 1999

32. Registrar's Signature: Linda B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25678

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John Genczo
2. Date of Death (Month, Day, Year): August 10, 1999
3. Time of Death: 3:25 Pm
4a. Facility Name (If not institution, give street and number): 219 Crocker Drive, Apt. B
4b. City, Town, or Location of Death: Belair
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 340-18-3548
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 6-6-1922
9. Birthplace (State or Foreign Country): Illinois

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Belair
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 219 Crocker Drive Apt. B
10f. Zip Code: 21014
10g. Citizen of What Country?: U. S. A.
11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Parts Manager
16b. Kind of Business/Industry: Auto Dealer
17. Father's Name (First, Middle, Last): George Genczo
18. Mother's Name (First, Middle, Maiden Surname): Anna Dusko
19a. Informant's Name/Relationship (Type, Print): Mr. George D. Benson (Son In Law)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5802 Eurith Ave., Baltimore, Maryland 21206
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Garrison Forest Cemetery
Date: 8-16-99
20c. Location - City or Town, State: Owings Mills, Maryland
21. Signature of Funeral Service Licensee: ▶ Wallace S. Brooks, Jr.
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. 21204

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. VENTRICULAR FIBRILLATION — minutes

Due to (or as a consequence of):
b. MYOCARDIAL INFARCTION — minutes.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. ARTERIOSCLEROTIC CORONARY ARTERY DISEASE — YEARS

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Lawrence F. Cuccia
29c. License number: D000391
29d. Date signed (Month, Day, Year): 8/12/99.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): LAWRENCE AUGHT 120 S. STOCKTON PIERCE DR. TOWSON, MD 21204.

State Registrar

31. Date filed (Month, Day, Year): AUG 17 1999
32. Registrar's Signature: ▶ Jennie D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25679

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Carol Grant
2. Date of Death (Month, Day, Year): August 10 1999
3. Time of Death: 9AM
4a. Facility Name (If not institution, give street and number): 13 Margaret Avenue
4b. City, Town, or Location of Death: Pasadena
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 212-32-2588
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 66 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 06, 1932
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Pasadena
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 13 Margaret Avenue
10f. Zip Code: 21122
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Household

17. Father's Name (First, Middle, Last): Bronzie Lewis
18. Mother's Name (First, Middle, Maiden Surname): Catherine Mueller

19a. Informent's Name/Reletionship (Type, Print): Deborah D. Clews (daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7646 4th Street, Pasadena, MD. 21122

20a. Method of Disposition: 1☒ Buriel 2☐ Cremation 3☐ Removal from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Name of cemetary, crematory or other place): Meadowridge Cemetery | Date: Aug, 13, 1999
20c. Location - City or Town, State: Elkridge, Maryland

21. Signeture of Funerel Service Licensee: [signature]
22. Name and Address of Facility: Stallings Funeral Home P.A. 3111 Mountaine, Pasadena, 21122

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions thet ceased the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each lina. (Approximate Interval Between Onset end Death)

Immediate Ceuse (Final diseese or condition resulting in death): e. Cirrhosis
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest
b. Methotrexate toxicity
Due to (or es e consequence of):
c.
Due to (or es a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.
Renal failure
Psoriasis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☑ No
24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only ona): Hospitel: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)
27. Mannar of Death: 1☑ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Panding investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Pleca of Injury - At homa, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. 2☐ Medical Examiner: On tha basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] MD
29c. License number: D41907
29d. Date signed (Month, Day, Year): 8/11/99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jose Perez-Alou 3708 Mountain Road Pasadena MD 21122

State Registrar

31. Date filed (Month, Day, Year): AUG 17 1999
32. Registrar's Signature: Donna B. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25680

Certificate of Death

Amended Item#16b perFH G774 8/17/99 EW

Reg. No.

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): DONALD, ALBERT, GRAMMER

2. Dete of Death: Month August Day 13 Yeer 1999

3. Time of Death: 12:38A

4e. Facility Name (If not institution, give street and number): SINAI HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-32-6205

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 64 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 28, 1935

9. Birthplece (State or Foreign Country): Baltimore, Maryland

Usuel Residence of Decedent

10e. Stete: Maryland

10b. County: Baltimore Co.

10c. City, Town or Location: Lutherville

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street end Number: 1823 Ridgeway Ave.

10f. Zip Code: 21093

10g. Citizen of Whet Country?: United States of America

11. Marital Stetus: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yeer or Dates: Korean Conflict

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:

14. Rece - Americen Indien, Bleck, White, etc. Specify: White

15. Decedent's Educetion (Specify only highest grade completed): Elementary/Secondary (0-12): 11 | College (1-4or 5+): N/A

16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Railroad Engineer

16b. Kind of Business/Industry: Patapsco and Back River ~~Neck~~ Railroad

17. Father's Neme (First, Middle, Last): Corry Grammer

18. Mother's Name (First, Middle, Maiden Surname): Marie Ecklend

19e. Informent's Neme/Relationship (Type, Print): (Wife) Mrs. Phyllis Laura(nee Cantler)Grammer

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1823 Ridgeway Ave. Lutherville, Maryland 21093

20e. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)

20b. Place of Dispositlon (Name of cemetery, crematory or other place): Druid Ridge Cemetery

Dete: 8/16/1999

20c. Location - City or Town, State: Baltimore, Maryland

21. Signeture of Funeral Service Licensee: ▶ Jeffrey L. Gair

22. Neme end Address of Fecility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Maryland 21204

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediete Ceuse (Final disease or condition resulting in death): a. TOXIC ENCEPHALOPATHY

Due to (or as a consequence of):

Sequentially list conditions, if eny, leeding to Immediate ceuse. Enter Underlying Cause (Disease or injury thet initieted events resulting in deeth) Lest

b.

Due to (or es a consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other signlficant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

CONGESTIVE HEART FAILURE

DIABETESE

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24e. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1 [ ] Yes 2 [X] No

25. Wes cese referred to medicel examiner? 1 [ ] Yes 2 [X] No

26. Piece of Deeth (Check only one): Hospitel: 1 [X] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Menner of Deeth: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and place, end due to the cause(s) and manner es steted. 2 [ ] **Medical Examiner:** On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) end manner stated.

29b. Signeture end title of certifier: ▶ Edward Davis MD

29c. License number: P13212

29d. Date signed (Month, Day, Year): August 13 1999

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print): EDWARD DAVIS SINAI Hospital Baltimore MD

State Registrar

31. Dete filed (Month, Day, Year): AUG 17 1999

32. Registrar's Signature: ▶ G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Associated Pr
BALTIMORE, MARYLA

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25681

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: HERBERT WILBERT GARRETT
2. Date of Death Month Day Year: August 15, 1999
3. Time of Death: 4:00 AM
4a. Facility Name *(If not institution, give street and number)*: 6542 Parnell Avenue
4b. City, Town, or Location of Death: Dundalk
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 213-07-0700
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Jan. 20, 1913
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 6542 Parnell Avenue
10f. Zip Code: 21222
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Evar in U.S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva Year or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 ☐ Yes 2 ☒ No *Specify:*
14. Race - American Indian, Black, Whita, atc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 Years | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Machinist
16b. Kind of Business/Industry: Steel Industry

17. Father's Name *(First, Middle, Last)*: Archibald Garrett
18. Mothar's Name *(First, Middle, Maiden Surname)*: Margaret Schailie

19a. Informant's Name/Relationship *(Type, Print)*: Mrs. Dorothy Garrett/Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6542 Parnell Avenue Dundalk, Maryland 21222

20a. Mathod of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Ptace of Disposition *(Nama of cemetery, crematory or other place)*: Sacred Heart of Jesus Cem. | Data: 8/18/99
20c. Location - City or Town, Stata: Dundalk, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Nama and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part1. Entar the disease, or complications that caused tha death. Do not entar tha moda of dying, such as cardiac or raspiratory arrast, shock, or heart feilure. List only one cause on each line. — Approximata Intarval Batwaen Onset and Death

Immedieta Causa (Finat disease or condition rasulting in death): a. Congestive Heart Failure
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Dua to (or as a consequence of):
c. Dua to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Wara autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was casa raferred to medical examiner? 1 ☐ Yas 2 ☒ No
26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Homa 5 ☒ Residence 6 ☐ Othar *(Specify)*
27. Mannar of Death: 1 ☒ Naturat 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Data of Injury *(Month, Day Year)* | 28b. Tima of Injury | 28c. Injury at Work? 1 ☐ Yes 2 ☐ No | 28d. Describe how injury occurred
28a. Place of Injury - At homa, farm, street, factory, office building, etc. *(Specify)* | 28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: 1 ☒ **Certifying Physician:** To tha best of my knowledge, daath occurrad at tha tima, data and placa, and due to tha causa(s) and mannar as stated. 2 ☐ **Medical Examiner:** On tha basis of examinetion and/or investigation, in my opinion, deeth occurred at tha time, data and place, and dua to tha cause(s) and manner stated.
29b. Signatura and titla of certifier: K.S. Schendel MD
29c. License number: D39758
29d. Data signed *(Month, Day, Year)*: 8-16-99
30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): Kevin G. Schendel MD 9101 Franklin Sq. Drive, Suite 321

State Registrar

31. Data filed *(Month, Day, Year)*: AUG 17 1999
32. Registrar's Signatura: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25682

NAME: Gott, Audrey Sophie

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: AUDREY SOPHIE GOTT
2. Date of Death: Month August Day 14, Year 1999
3. Time of Death: 2:55P.M.

4a. Facility Name *(If not institution, give street and number)*: Reeders Memorial Home
4b. City, Town, or Location of Death: Boonsboro
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 220-03-0540
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 93 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: March 12, 1906
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Boonsboro
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 141 Main Street
10f. Zip Code: 21713
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Saleslady
16b. Kind of Business/Industry: Clothing

17. Father's Name *(First, Middle, Last)*: Frederick Kahl
18. Mother's Name *(First, Middle, Maiden Surname)*: Edna Klein

19a. Informant's Name/Relationship *(Type, Print)*: Frederick Warnken - son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7318 Wheeler Rd., Boonsboro, Md. 21713

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Loudon Park Cem. Aug. 18, 1999
20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: ▶ J. Dale Eckhardt
22. Name and Address of Facility: Eckhardt Funeral Chapel 11605 Reisterstown Rd. Owings Mills, Md. 21117

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. *Approximate Interval Between Onset and Death*

Immediate Cause (Final disease or condition resulting in death): e. ASPIRATION PNEUMONITIS

Due to (or as a consequence of): CONGESTIVE HEART FAILURE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: ALZHEIMERS DISEASE; DIVERTICULOSIS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ MD
29c. License number: D52055
29d. Date signed *(Month, Day, Year)*: 8-15-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Zubair Syed 130 West High Street, Hancock, Maryland 21750 (301) 678-7256

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 17 1999
32. Registrar's Signature: ▶ Denise G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25683

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
Mary Ursula Golobic	August	14	1999	2:35 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Villa Assumpta	Baltimore	Baltimore

Funeral Director

5. Social Security Number	8. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-58-6676	1☐ M 2☒ F	90 Yrs.			March 8, 1909	Pennsylvania

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Baltimore	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6401 N. Charles St.	21212	United States

11. Meritel Sfetus	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.)	14. Race - American Indian, Bleck, White, etc.
1☒ Never Married 2☐ Merried 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	4	teacher	education

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Sumame)
John Golobic	Anna Boyance

19a. Informant's Name/Reletionship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Sr. Caroleen Baummer/	6401 N. Charles St. Baltimore, MD 21212

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other piece)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removel from Stete 4☐ Donation 5☐ Other (Specify)	Villa Maria Cemetery	8/17/99	Glen Arm, Maryland

21. Signature of Funerel Service Licensee	22. Name and Address of Facility
▶ John O. Mitchell IV	Mitchell-Wiedefeld Funeral Home, Inc 6500 York Rd. Baltimore, MD 21212

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicefions that caused the deeth. Do not enter the mode of dying, such es cerdiec or respirefory errest, shock, or heert failure. List only one ceuse on eech line.

		Approximate Interval Between Onset and Death
Immediate Ceuse (Final disease or condition resulting in death)	a. EMPHYSEMA & CHRONIC OBSTRUCTIVE PULMONARY DISEASE	1YR
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. CONGESTIVE HEART FAILURE	1YR
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death?	24a. Wes an autopsy performed?	24b. Ware autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown	1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Francis Xavier Carmody MD	MD 1373	AUG 16 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
FRANCIS XAVIER CARMODY

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
AUG 17 1999	▶ Irene B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25684

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARGARET CORRIGAN GEBB
2. Date of Death (Month, Day, Year): AUGUST 13, 1999
3. Time of Death: 3:15PM
4a. Facility Name (If not institution, give street and number): Saint Joseph Medical Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 213-10-1512
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 9, 1916
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 88 Murdock Rd.
10f. Zip Code: 21212
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedant Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Yaar or Dates:
13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, atc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Educetion (Specify only highest grade completed): Elementery/Secondary (0-12): 12 yrs. | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CLERK
16b. Kind of Business/Industry: Medical Insurance Co.

17. Father's Name (First, Middle, Last): JOSEPH CORRIGAN
18. Mother's Name (First, Middle, Meiden Surneme): KATHERINE MADDOX

19e. Informant's Name/Reletionship (Type, Print): FAY ANDREWS Daughter
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 4407 Sweet Air Rd. Baldwin.Maryland 21013

20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other pieca): Parkwood Cemetery | Date: 8/17/99
20c. Location - City or Town, State: Parkville, Maryland

21. Signature of Funeral Service Licensee: Robert M. Kratz
22. Name and Address of Fecility: Mitchell-Wiedefeld Funeral Home Inc. 6500 York Rd. 21212

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter tha mode of dying, such es cerdiac or raspiratory arrast, shock, or heart feilure. List only one causa on each line. (Approximate Interval Between Onset and Death)

Immediete Ceuse (Final disaase or condition resulting in death): e. ACUTE RESPIRATORY DISTRESS SYNDROME

Due to (or es a consequence of): PNEUMONIA

Sequentially tist conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Dtseese or tnjury thet initieted events resulting in deeth) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other stgnificant conditions** contributing to death but not resulting in the underlying cause given in Part I.: **CARCINOMA OF URETER**

23b. Dtd tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Was cese rafarrad to medicel examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Homa 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of tnjury (Month, Dey Year)
28b. Time of Injury M
28c. tnjury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of tnjury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certtfying Phyetcian:** To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the ceuse(s) end manner es stated. 2☐ **Medtcal Examiner:** On the basis of examinetion and/or Investigetion, in my opinion, death occurred et the time, date end plece, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: Francis Khoo
29c. License number: D30263
29d. Date signed (Month, Day, Year): 8-13-99

30. Name end eddress of person who completed ceuse of death (Item 23e) (Type, Print): FRANCIS KHOO, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204

State Registrar

31. Dete filed (Month, Day, Yeer): AUG 17 1999
32. Registrar's Signature: Lorrie D. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificete be executed within 24 hours efter death.
To the Funeral Director: After this certificete has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25685

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: STEPHANIE (STELLA) GORSKI

2. Data of Death Month: AUGUST Day: 8, Yaar: 1999

3. Time of Death: 0920

4a. Facility Nama *(If not institution, giva street and number)*: CHURCH HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Securily Number: 212-09-0517

6. Sex: 1☐ M 2☒ F

7. Aga *(In yrs. last birthday)*: 85 Yrs. If Undar 1 Yaar: Months / Deys. If Undar 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Day, Year)*: 6/22/14

9. Birthplace *(State or Foreign Country)*: MD.

Usuel Residence of Decedant

10e. Stete: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limils: 1☒ Yes 2☐ No

10e. Street end Number: 2502 FLEET STREET

10f. Zip Code: 21224

10g. Citizen of What Country?: U.S.A.

11. Maritel Status: 1☒ Navar Married 2☐ Married 3☐ Widowad 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yes, Give Year or Datas:

13. Was Dacedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puerto Ricen, etc.) 1☐ Yes 2☒ No *Specify:*

14. Rece - Americen Indian, Bleck, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12 College (1-4or 5+): 0

16a. Decedant's Usual Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: ASSEMBLER

16b. Kind of BusInass/Industry: PRINTING

17. Father's Name *(First, Middle, Last)*: STANISLAUS GORSKI

18. Mother's Name *(First, Middle, Maiden Surname)*: WANDA RYDCEWSKI

19a. Intormant's Name/Reletionship *(Type, Print)*: MR FRED ZOLONAS

19b. Mailing Addrass *(Straet and Number or Rural Route Number, City or Town, State, Zip Code)*: 12 JULIET LA. #102 BALTIMORE, MD. 21236

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Placa of Disposition *(Nama of cametary, crematory or other place)*: HOLY ROSARY CEME. Dete: 8/11/99

20c. Location - City or Town, Stete: BALTO., MD.

21. Signeture of Funeral Sarvica Licensee: Charles Kaczorowski

22. Nama end Address of Fecility: KACZOROWSKI FUNERAL HOME P.A. 2525 FLEET ST. BALTO., MD. 21224

Physician /Medical Examiner

23a. Pert1. Entar tha disease, or complications thal caused tha death. Do not enter tha moda of dying, such as cardiac or respiratory arrest, shock, or heart feilura. List only one cause on each line.

Approximata Intervel Between Onsat and Death

Immediata Cause (Finel disaasa or condition resulting in death)
e. Acute Renal failure — 12 hours

Due to (or es a consequanca of):
b. Acute MI — 5days

Sequentielly list conditions, if eny, leeding to immediata ceuse. Enter Underlying Cause (Diseasa or injury that initiated events resulting in daath) Lest

Due to (or as a consequanca of):
c. Acute Resp. failure — 5days

Due to (or as e consequence of):
d. sepsis — 4days

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Wara autopsy findings available prior to completion of cause of daath? 1☐ Yes 2☑ No

25. Wes cese rafarred to medicel examiner? 1☐ Yas 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☑ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Panding Invastigation 6☐ Could not be datarmined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Dascribe how injury occurred

28e. Piece of Injury - At home, farm, straat, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To tha best of *my* knowledge, deeth occurred at tha time, data and placa, and dua to tha causa(s) and mannar as stated. 2☐ **Medicel Examiner:** On the basis of exemination end/or invastigation, in my opinion, daath occurred at tha time, data and place, and dua to tha causa(s) and mannar stated.

29b. Signetura end title of certifier: Zoney Lee Lewis M.D.

29c. License numbar: D. 12962

29d. Data signed *(Month, Day, Year)*: 08-08-99

30. Name and address of person who completed ceusa of daath (Item 23e) (Type, Print): Zoney Lee Lewis 8909 old Brown Cow Circle, Md 20735

State Registrar

31. Date filed *(Month, Day, Yaar)*: AUG 17 1999

32. Registrar's Signature: Donna G. Sparks

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

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DHMH 16 Rev 6/95

Please Type or Print In Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25686

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Virginia Alice Henderson
2. Date of Death (Month, Day, Year): August 15, 1999
3. Time of Death: 3:00 p.m.
4a. Facility Name (If not institution, give street and number): 2911 Dunran Road
4b. City, Town, or Location of Death: Dundalk
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 219-32-1308
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 63 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 6, 1935
9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2911 Dunran Road
10f. Zip Code: 21222
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 9 | College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): George Washington Fair
18. Mother's Name (First, Middle, Maiden Surname): Alice Gutridge

19e. Informant's Neme/Reletionship (Type, Print): Dawn Haven (daughter)
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9 Eugene Avenue, Baltimore, Maryland 21221

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Piece of Disposition (Name of cemetery, crematory or other place): Meadow Ridge Cemetery
Date: 8/18/1999
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Richard Bruzdzinski
22. Name and Address of Facility: Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that eiused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only coe cause on each line.

Approximate Interval Between Onset and Death

Immediete Ceuse (Final diseese or condition resulting in deeth)
e. ACUTE MYOCARDIAL INFARCTION — 1 HR.
Due to (or es a consequence of):
b. Arteriosclerotic Heart Disease — 10 YRS.

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in deeth) Last
Due to (or es e consequenca of):
c.
Due to (or es e consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Rheumatic Heart Disease
S/P Mitral Valve Replacement

23b. Did tobecco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes an eutopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒ Certifying Phyaician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated. 2☐ Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steted.

29b. Signature and title of certifier: M.D.
29c. License number: D17728
29d. Date signed (Month, Day, Year): August 17, 1999

30. Neme and address of parson who completed cause of deeth (Item 23a) (Type, Print): Ba Yin Oung, M.D. 8022 Belair Rd. Balto., MD 21236

State Registrar

31. Dete filed (Month, Day, Year): AUG 17 1999
32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25687

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ruth C. Hurd

2. Date of Death: Month August Day 14th Year 1999

3. Time of Death: 3:30Am

4a. Facility Name (If not institution, give street and number): Carroll County Gen. Hosp

4b. City, Town, or Location of Death: Westminster

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 213-20-8146

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 75 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 1, 1924

9. Birthplace (State or Foreign Country): Maryland

Usuel Residenca of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Cockeysville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 10120 Daventry Dr.

10f. Zip Code: 21030

10g. Citizen of What Country? USA

11. Maritel Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yas, Giva Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cashier

16b. Kind of Business/Industry: Department Store

17. Father's Name (First, Middle, Last): George W. Horn

18. Mother's Name (First, Middle, Maiden Surneme): Louise Tegges

19a. Informent's Name/Relationship (Type, Print): Elizabeth A. Schmuff/Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10120 Daventry Dr. Cockeysville, MD 21030

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Piece of Disposition (Name of cemetery, cremetory or other place): Loudon Park Cemetery

Date: August 17, 1999

20c. Location - City or Town, Stete: Baltimore, MD

21. Signature of Funeral Service Licensee: Michael J. Flagle

22. Nama end Address of Facility: Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Road Timonium, MD 21093

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Sepsis — Two DAYS

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last

b.

Due to (or es e consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Stroke, Diabetes, multiple Sclerosis.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was casa referred to medical examinar? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: MD

29c. License number: D48006

29d. Date signed (Month, Day, Year): August 14th, 1999

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): KOFi BOAiTEY, 200 memorial Ave, Westminster, MD 21157

State Registrar

31. Date filed (Month, Day Year): AUG 17 1999

32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Ruth Hurd

AJ

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND#20a-20c PER F.H. G774 8-24-99 J.A.

Certificate of Death

Reg. No. 99 25688

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): KENNETH HILL

2. Date of Death: Month August Day 11 Year 1999

3. Time of Death: 900 AM

4a. Facility Name (If not institution, give street and number): Maryland General Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-56-2179

6. Sex: 1 X M 2 ☐ F

7. Age (In yrs. last birthday): 46 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 8-9-53

9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD. | 10b. County: N/A | 10c. City, Town or Location: BALTIMORE | 10d. Inside City Limits: 1 X Yes 2 ☐ No

10e. Street and Number: 1506 BAKER ST. | 10f. Zip Code: 21217 | 10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 X Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): -12- | College (1-4or 5+): -0-

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): DISABLED

16b. Kind of Business/Industry: N/A

17. Father's Name (First, Middle, Last): LOUIS HILL

18. Mother's Name (First, Middle, Maiden Surname): JUDITH PARKER

19a. Informant's Name/Relationship (Type, Print): DEBRA HILL(SISTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1506 BAKER ST. BALTIMORE, MARYLAND 21217

20a. Method of Disposition: 1 X Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): ~~GARRISON FOREST VETERANS~~ METRO CREMATORY | Date: 8-18-99

20c. Location - City or Town, State: ~~OWINGS MILLS, MARYLAND~~ BALTIMORE MARYLAND

21. Signature of Funeral Service Licensee: ▶ Doretha Hector CFSP

22. Name and Address of Facility: PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217

Physician Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Sepsis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

28. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28e. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ A Chandok

29c. License number: 89346

29d. Date signed (Month, Day, Year): 8/11/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ARUN CHANDOK, M.D. C/O Maryland General Hospital.

State Registrar

31. Date filed (Month, Day, Year): AUG 17 1999

32. Registrar's Signature: Regina B. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

HILL, KENNETH

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25689

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Helen Florence Hummer

2. Date of Death (Month, Day, Year): August 15 1999

3. Time of Death: 6:10 pm

4a. Facility Name *(If not institution, give street and number)*: FutureCare - Chesapeake

4b. City, Town, or Location of Death: Arnold

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 212-74-9702

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 93 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: Nov. 25, 1905

9. Birthplace *(State or Foreign Country)*: Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Arnold

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 305 College Parkway

10f. Zip Code: 21012

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Richard Hashagen

18. Mother's Name *(First, Middle, Maiden Surname)*: Blanch Schultz

19a. Informant's Name/Relationship *(Type, Print)*: Ruth Routzahn (Daughter)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1130 Bragers Road, Odenton, MD 21113

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Windy Hill Cemetery

Date: 08/18

20c. Location - City or Town, State: Easton, Maryland

21. Signature of Funeral Service Licensee: Michael P. Kuttas

22. Name and Address of Facility: Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE HEART FAILURE — 15 YEARS

Due to (or as a consequence of):

b. ISCHEMIC HEART DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

EMPHYSEMA

DIABETES

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D21776

29d. Date signed *(Month, Day, Year)*: AUGUST 17 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SURYA MUNDRA MD 8109 RITCHIE HWY PASADENA MD 21122

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 17 1999

32. Registrar's Signature: G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

8

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25690

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Rosalie Heath

2. Date of Death (Month, Day, Year): August 12, 1999

3. Time of Death: 8:00 p.m.

4a. Facility Name (If not institution, give street and number): 6002 Alta Avenue

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-28-0946

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 66 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 26, 1932

9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: XX 1☒ Yes 2☐ No

10e. Street and Number: 6002 Alta Avenue

10f. Zip Code: 21206

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced XX

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Vincent Sanzone

18. Mother's Name (First, Middle, Maiden Surname): Grace Tumminello

19a. Informant's Name/Relationship (Type, Print): Maria Absalom (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4215 Heckel Avenue, Baltimore, MD 21206

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Garrison Forest VA Cem. Date: 8/17/99

20c. Location - City or Town, State: Owings Mills, MD

21. Signature of Funeral Service Licensee: ▶ Robert J Rodel

22. Name and Address of Facility: Schimunek Funeral Home, Inc. 9705 Belair Road, Baltimore, MD 21236

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Biliary carcinoma

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ M.D.

29c. License number: D52197

29d. Date signed (Month, Day, Year): 08-13-1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Rekha Motagi 7544 Holabird Avenue, Baltimore MD 21222

State Registrar

31. Date filed (Month, Day, Year): AUG 17 1999

32. Registrar's Signature: ▶ Donna G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25691

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: WILLIAM A. HUDSON

2. Date of Death Month: AUGUST Day: 11 Year: 1999

3. Time of Death: 9:00 PM

4a. Facility Name *(If not institution, give street and number)*: 3726 ELLERSIE AVENUE

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-34-6732

6. Sex: XX 1 M 2 F

7. Age *(In yrs. last birthday)*: 61 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 06-05-1938

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MD.

10b. County: N/A

10c. City, Town or Location: BALTIMORE CITY

10d. Inside City Limits: XX 1 Yes 2 No

10e. Street and Number: 3726 ELLERSIE AVENUE

10f. Zip Code: 21218

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 Never Married XX 2 Married 3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 Yes XX 2 No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes XX 2 No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 YEARS / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: MACHANIST

16b. Kind of Business/Industry: BLACK & DECKER

17. Father's Name *(First, Middle, Last)*: JOHN C. HUDSON, SR.

18. Mother's Name *(First, Middle, Maiden Surname)*: ELIZABETH C. UTTER

19a. Informant's Name/Relationship *(Type, Print)*: MARTHA G. HUDSON (WIFE)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3726 ELLERSIE AVENUE, BALTIMORE, MD., 21218

20a. Method of Disposition: 1 Burial XX 2 Cremation 3 Removal from State 4 Donation 5 Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: GREEN MOUNT CREMATORY Date: 8-16

20c. Location - City or Town, State: BALTO., MD., 21202

21. Signature of Funeral Service Licensee: R. D. Ruth

22. Name and Address of Facility: HENRY W. JENKINS AND SONS COMPANY 4905 YORK ROAD, BALTIMORE, MARYLAND, 21212

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Metastatic colorectal cancer — ~2 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes XX 2 No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes ✓ 2 No

26. Place of Death *(Check only one)*: Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home XX 5 Residence 6 Other *(Specify)*

27. Manner of Death: XX 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: XX 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Paul Chang, MD

29c. License number: D16587

29d. Date signed *(Month, Day, Year)*: AUGUST 12, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): PAUL CHANG, M.D., 5601 LOCH RAVEN BOULEVARD, BALTIMORE, MARYLAND, 21239

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 17 1999

32. Registrar's Signature: Jenna G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

A415

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25692

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Luther Edward Heim, Sr.
2. Date of Death (Month, Day, Year): AUGUST 14, 1999
3. Time of Death: 12:32PM
4a. Facility Name (If not institution, give street and number): Saint Joseph Medical Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 219-44-8959
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 53 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 12 1946
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md
10b. County: Baltimore
10c. City, Town or Location: Parkville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 3044 Edgewood Ave.
10f. Zip Code: 21234
10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): —
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): disabled
16b. Kind of Business/Industry:

17. Father's Name (First, Middle, Last): Luther E. Heim, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Mabel A. Fischer

19a. Informant's Name/Relationship (Type, Print): Sandy Schaaf Sister
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 6909 Harewood Park Dr. Balto. Md 21220

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Evans Funeral Chapel-Belair Date: Aug. 17 1999
20c. Location - City or Town, State: Forest Hell, Maryland
21. Signature of Funeral Service Licensee: Krista L. Wells
22. Name and Address of Facility: Evans Funeral Chapel 8800 Harford Rd Baltimore, Md 21234

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. SEPSIS	WEEKS
Due to (or es e consequence of):	a. LIVER FAILURE	YEARS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in death) Last	b. Due to (or as a consequence of): CORONARY ARTERY DISEASE	WEEKS
	c. Due to (or as a consequence of): HEPATITIS C	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24e. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and pieca, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: James F. Lamb
29c. License number: D54583
29d. Date signed (Month, Day, Year): 8/14/99

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): THOMAS CAPPOLA, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204

State Registrar

31. Date filed (Month, Day, Year): AUG 17 1999
32. Registrar's Signature: Linda B. Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate hes been signed by the attending physician end completely filled in by the funeral director, pege 2 should be detached for use as the burial-transit permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25693

STANISLAUS JANKOWSKI

Baltimore, Maryland 21215-0020 NAME KNOWN TO PHYSI

permit. Pages 1 and 2 should be filed within 72 hours after death. Medical Certification: To be completed by Physician/Medical Examiner. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Stanislaus Jankowski
2. Date of Death: Month AUGUST Day 9 Year 1999
3. Time of Death: 2240
4a. Facility Name (If not institution, give street and number): Church Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-32-6330
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 10-22-11
9. Birthplace (State or Foreign Country): Poland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 2622 E. Baltimore St.
10f. Zip Code: 21224
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 4 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Landlord
16b. Kind of Business/Industry: Home Rentals
17. Father's Name (First, Middle, Last): Alexander Jankowski
18. Mother's Name (First, Middle, Maiden Surname): unknown
19a. Informant's Name/Relationship (Type, Print): Mr. Henry Jankowski
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2622 E. Baltimore St., Baltimore, MD 21224
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): St. Stanislaus | Date: 8-13-99
20c. Location - City or Town, State: Balto., MD
21. Signature of Funeral Service Licensee: Charles Kaczorowski
22. Name and Address of Facility: Kaczorowski Funeral Home, 1201 Dundalk Avenue, Balto., MD 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	ACUTE MYOCARDIAL INFARCTION	2 hr.
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.	HYPERTENSIVE HEART DISEASE	YEARS
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☑ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ER ATTENDING
29c. License number: D 40356
29d. Date signed (Month, Day, Year): AUGUST 9, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): WENELISA NAVARRO, MD. 100 N. Broadway, Baltimore, MARYLAND 21231

State Registrar

31. Date filed (Month, Day, Year): AUG 17 1999
32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25694

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Thelma G. Kess
2. Date of Death Month Day Year: Aug. 12, 1999
3. Time of Death: 9:15AM
4a. Facility Name (If not institution, give street and number): Chesapeake Hospice House
4b. City, Town, or Location of Death: Linthicum
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 216-10-8545
6. Sex: 1☐ M 2☑ F
7. Age (If yrs. last birthday): 92 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 3, 1907
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10e. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Glen Burnie
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 1414 John Street
10f. Zip Code: 21061
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 3 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Foster Grandparent
16b. Kind of Business/Industry: Anne Arundel Co.

17. Father's Name (First, Middle, Last): Frank Goldsborough
18. Mother's Name (First, Middle, Maiden Surname): Laura Boone

19a. Informant's Name/Relationship (Type, Print): Edward L. Mitchell
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1414 John Street Glen Burnie, Md 21061

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Zion Church Cem. | Date: 8/18/99
20c. Location - City or Town, State: Pasadena, Md.

21. Signature of Funeral Service Licensee: Gloria Adams Jones
22. Name and Address of Facility: Marshall W. Jones, Sr. F.A., P.A. 4101 Edmondson Ave. Balto. Md. 21229

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
e. - Congestive Heart Failure 2° #2

Due to (or as a consequence of):
b. - Congestive CVD

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
c. - Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☑ Other (Specify) Hospice

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☑ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: 025782
29d. Date signed (Month, Day, Year): 8/13/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): S. Izzi, M.D. 1575 Ritchie Hwy Glen Burnie Md 21061

State Registrar

31. Date filed (Month, Day, Year): AUG 17 1999
32. Registrar's Signature: Diane D. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25695

AMENDED ITEM #5 PER FH G774 8/23/99 AH

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Rosalie Lofton

2. Date of Death: Month August Day 16, Year 1999

3. Time of Death: 8:30 a.m.

4a. Facility Name (If not institution, give street and number): 117 Dihedral Drive

4b. City, Town, or Location of Death: Middle River

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: ~~213-26-5984~~ ~~216-14-1701~~

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 69 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 20, 1930

9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Middle River

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 13 Walkway Court

10f. Zip Code: 21220

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Home Maker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): William M. Alt

18. Mother's Name (First, Middle, Maiden Surname): Ida Ours

19a. Informant's Name/Relationship (Type, Print): Sharon R. Burns (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 117 Dihedral Drive, Baltimore, Maryland 21220

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Holly Hill Mem. Gardens

Data: 8/19/99

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Richard Bruzdzinski

22. Name and Address of Facility: Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute / Sudden Cardiac Death — 10 min

Due to (or as a consequence of):
b. Arrythmia — 10 min

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Ware autopsy findings available prior to complation of cause of death? 1☐ Yas 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only ona)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Daughter's Home

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Data of Injury (Month, Day Year)

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, data and place, and due to tha cause(s) and manner stated.

29b. Signatura and title of certifier

29c. License number: D44604

29d. Data signed (Month, Day, Year): 8/17/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MICHAEL SMEI MD 8100 HARFORD RD BALTIMORE MD 21234

State Registrar

31. Data filed (Month, Day, Year): AUG 17 1999

32. Registrar's Signatura: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25696

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LOUISE CORE LAMB

2. Date of Death: Month AUGUST Day 16 Year 1999

3. Time of Death: 17:44

4a. Facility Name (If not institution, give street and number): SINAI HOSPITAL OF BALTIMORE

4b. City, Town, or Location of Death: BALTIMORE CITY

4c. County of Death:

Funeral Director

5. Social Security Number: 218-10-9482

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 82 Yrs.

If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 12, 1917

9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Md.

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3207 West Rodgers Ave.

10f. Zip Code: 21215

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Waitress

16b. Kind of Business/Industry: Resturant

17. Father's Name (First, Middle, Last): Russell B.Brashear

18. Mother's Name (First, Middle, Maiden Surname): Ellise May Fritz

19a. Informant's Name/Relationship (Type, Print): Anna Hastings - daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 262 West Woodbine Road Fawngrove, Pa. 17321

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory

Date: Aug. 19, 1999

20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: Justin R. Hoover

22. Name and Address of Facility: Eckhardt Funeral Chapel 21117, 11605 Reisterstown Rd. Owings Mills, Md.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. MASSIVE BRAINSTEM INFARCT — 5days

Due to (or es e consequence ot):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last

b. Aberrant (R) Subclavian Artery Aneurysm

Due to (or es e consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings aveileble prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es steted. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date and place, and due to the ceuse(s) end manner stated.

29b. Signature end title of certifier

29c. License number: RES 000

29d. Date signed (Month, Day, Year): 08/16/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): EDWARD SMITH MD. SINAI HOSPITAL OF BALTIMORE

State Registrar

31. Date filed (Month, Day, Year): AUG 17 1999

32. Registrar's Signature: Theresa B. Sparks

DHMH 16 Rev 6/95

A40

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25697

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ROBERT L. MILLER, SR.
2. Data of Daath — Month: 08 Day: 13 Year: 99
3. Tima of Death: 8 00 AM
4a. Facility Nama (If not institution, giva street and number): 7033 LONGVIEW ROAD
4b. City, Town, or Location of Death: COLUMBIA
4c. County of Death: Howard

Funeral Director

5. Social Security Number: 183-28-6807
6. Sax: 1 ☑ M 2 ☐ F
7. Aga (In yrs. last birthday): 63 Yrs. — If Undar 1 Yaar: Months / Days — If Undar 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Yaar): 09-12-35
9. Birthplaca (Stata or Foraign Country): KENTUCKY

Usual Rasidanca of Decadant

10a. State: MD
10b. County: Howard
10c. City, Town or Location: COLUMBIA
10d. Inside City Limits: 1 ☐ Yas 2 ☑ No
10a. Street and Number: 7033 LONGVIEW ROAD
10f. Zip Coda: 21044
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Navar Marriad 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorcad
12. Was Decadant Evar in U.S. Armed Forcas? 1 ☑ Yas 2 ☐ No — If Yas, Giva Yaar or Datas:
13. Was Dacadant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 ☐ Yas 2 ☑ No Specify:
14. Race - Amarican Indian, Black, White, atc. Specify: BLACK

15. Decadant's Education (Specify only highast grada complatad) — Elamentary/Secondary (0-12): 12TH GRADE — Collaga (1-4or 5+): 2 YRS
16a. Decadant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratirad)
16b. Kind of Businass/Industry: POST OFFICE

17. Fathar's Nama (First, Middla, Last): TILMAN MILLER
18. Mothar's Nama (First, Middla, Maidan Surnama): INEAZER THORNTON

19a. Informant's Name/Ralationship (Type, Print): BARBARA MILLER / WIFE
19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 7033 LONGVIEW RD., COLUMBIA MD. 21044

20a. Mathod of Disposition: 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Othar (Spacify)
20b. Place of Disposition (Name of camatary, cramatory or other place): COLUMBIA MEMORIAL PARK
Data: 8-19-99
20c. Location - City or Town, Stata: COLUMBIA, MD

21. Signatura of Funaral Sarvica Licansaa: Vaughn C Greene
22. Name and Addrass of Facility: VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL PIKE, BALTO. MD. 21229

Physician /Medical Examiner

23a. Part1. Entar tha diaasa, or complications that causad tha daath. Do not antar tha mода of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only ona causa on aach lina.

Approximata Interval Batwaan Onsat and Death

Immadiata Causa (Final disaasa or condition rasulting in daath)
a. METASTATIC PROSTATE CANCER — ½ YEARS
Dua to (or as a consaquanca of):
Saquantially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disaasa or Injury that initiatad avants rasulting in daath) Last
b.
Dua to (or as a consaquanca of):
c.
Dua to (or as a consaquanca of):
d.

Part II. **Othar significant conditions** contributing to daath but not resulting in tha underlying cause given in Part I.

23b. Did tobacco usa contribute to the cause of death? 1 ☐ Yas 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yas 2 ☒ No
24b. Wara autopsy findings available prior to compliation of causa of daath? 1 ☐ Yas 2 ☐ No

25. Was casa rafarrad to medical examinar? 1 ☐ Yas 2 ☒ No
26. Placa of Daath (Check only ona) — Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatiant 3 ☐ DOA — Othar: 4 ☐ Nursing Homa 5 ☒ Rasidanca 6 ☐ Othar (Spacify)
27. Mannar of Daath: 1 ☒ Natural 2 ☐ Accidant 3 ☐ Suicida 4 ☐ Homicida 5 ☐ Panding Invastigation 6 ☐ Could not be datarminad
28a. Data of Injury (Month, Day Yaar)
28b. Tima of Injury M
28c. Injury at Work? 1 ☐ Yas 2 ☐ No
28d. Dascribe how injury occurrad
28a. Placa of injury - At homa, farm, straat, factory, offica building, atc. (Spacify)
28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifiar (Check only ona) 1 ☒ **Certifying Physician**: To the best of my knowladga, daath occurrad at tha tima, data and placa, and due to the causa(s) and mannar as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, daath occurrad at the time, data and placa, and due to tha cause(s) and mannar statad.
29b. Signatura and title of Cartifiar: Mario A. Eppurenger MD
29c. Licansa number: D28768
29d. Data signad (Month, Day, Yaar): 8/13/99
30. Nama and addrass of parson who complatad cause of daath (Item 23a) (Type, Print): MARIO A. EPPURENGER MD 600 N. WOLFE ST BALTIMORE, MD 21287

State Registrar

31. Data filad (Month, Day, Yaar): AUG 17 1999
32. Registrar's Signatura: Steven B. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25698

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): George MASON

2. Date of Death: Month August Day 9 Year 1999

3. Time of Death: 1:30 pm

4a. Facility Name (If not institution, give street and number): BON SECOURS HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 242-24-2698

8. Sex: 1 ☑ M 2 ☐ F

7. Age (In yrs. last birthday): 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 04-04-20

9. Birthplace (State or Foreign Country): NC

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 ☑ Yes 2 ☐ No

10e. Street and Number: 1819 N. BENTLOU STREET

10f. Zip Code: 21216

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12TH GRADE

College (1-4or 5+): N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): FORK LIFT DRIVER

16b. Kind of Business/Industry: ABERDEEN PROVING GROUND

17. Father's Name (First, Middle, Last): WILLIAM MASON

18. Mother's Name (First, Middle, Maiden Surname): GEORGIANNA PENNINGTON

19a. Informant's Name/Relationship (Type, Print): LAQUINTA MASON / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2013 BEARIDGE RD., BALTO. MD. 21222

20a. Method of Disposition: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): CROWNSVILLE CEMETERY

Date: 8-13-99

20c. Location - City or Town, State: CROWNSVILLE, MD

21. Signature of Funeral Service Licensee: Vaughn C Greene

22. Name and Address of Facility: VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL PIKE, BALTO. MD. 21229

Physician /Medical Examiner

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Adenocarcinoma of Liver — unknown

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Low Gastrointestinal Bleeding

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Anemia, Electrolyte Imbalance

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Kwang N. Kim MD

29c. License number: D17031

29d. Date signed (Month, Day, Year): August 09.1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): KWANG-N. KIM MD 2000 W. BALTIMORE ST. BALTIMORE, MD 21223

State Registrar

31. Date filed (Month, Day, Year): AUG 17 1999

32. Registrar's Signature: B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25699

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Polly Martak
2. Date of Death (Month, Day, Year): August 14, 1999
3. Time of Death: 5:45 pm
4a. Facility Name (If not institution, give street and number): 1039 Bayner Rd.
4b. City, Town, or Location of Death: Essex
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 214 38 4635
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 8, 1921
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Essex
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1039 Bayner Rd.
10f. Zip Code: 21221
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife
16b. Kind of Business/Industry: Own Home
17. Father's Name (First, Middle, Last): Unk.
18. Mother's Name (First, Middle, Maiden Surname): Unk. Wine
19a. Informant's Name/Relationship (Type, Print): Lana DiMartino Williams (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1104 Tace Dr. "Apt 3a" Baltimore, Md. 21221
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Moreland Memorial Park | Date: 8/18/1999
20c. Location - City or Town, State: Baltimore, Md.
21. Signature of Funeral Service Licensee: John W. Burkowske
22. Name and Address of Facility: Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Bladder cancer	6 months
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Sarah Shivanand MD
29c. License number: D 52379
29d. Date signed (Month, Day, Year): 8/16/99.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SAVITHA SHIVANANDA 1124 HACE AVE BALT MD 21221

State Registrar

31. Date filed (Month, Day, Year): AUG 17 1999
32. Registrar's Signature: Linda G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25700

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): SAMUEL A. MOULTON JR.

2. Date of Death: Month 8 Day 15 Year 99

3. Time of Death: 6:00 P.M

4a. Facility Name (If not institution, give street and number): 4852 Hawkbury Rd.

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

Funeral Director

5. Social Security Number: 213-58-0873

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 47 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 6 29 52

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☑ Yes 2 ☐ No

10e. Street and Number: 4852 Hawkbury Rd.

10f. Zip Code: 21208

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No. If Yes, Give Year or Dates: 70, 71, 72

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4 or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Administrator

16b. Kind of Business/Industry: State of Maryland

17. Father's Name (First, Middle, Last): Samuel A. Moulton SR.

18. Mother's Name (First, Middle, Maiden Surname): Shirley Adams

19a. Informant's Name/Relationship (Type, Print): Everlon Coffey - wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4852 Hawkbury Rd. 21208 Baltimore, Maryland

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Garrison Forest Cemetery

Date: 8-23-99

20c. Location - City or Town, State: Baltimore

21. Signature of Funeral Service Licensee: Jeff Miller

22. Name and Address of Facility: Jeff Miller funeral home 1639 N. Broadway

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. PANCREATIC CANCER — 4 MOS.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA. Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: G.I.C.

29c. License number: D27730

29d. Date signed (Month, Day, Year): 8/17/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GARY COHEN, MD 6569 N. CHARLES ST. BALTO MD 21204

State Registrar

31. Date filed (Month, Day, Year): AUG 17 1999

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

ORIGINAL

ADH
GERARD ERIC MARABLE
99-4645-510

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25701

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GERARD E. MARABLE JR.
2. Date of Death: Month AUGUST Day 10, Year 1999
3. Time of Death: 2030 PM
4a. Facility Name (If not institution, give street and number): JOHNS HOPKINS HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-98-9070
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 17 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 4-22-82
9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD.
10b. County: N-A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 1232 YOUNG CT.
10f. Zip Code: 21202
10g. Citizen of What Country? USA

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): -11- College (1-4or 5+): -0-
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): STUDENT
16b. Kind of Business/Industry: N/A

17. Father's Name (First, Middle, Last): GERARD E. MARABLE SR.
18. Mother's Name (First, Middle, Maiden Surname): SHERITA HOCUTT

19a. Informent's Name/Relationship (Type, Print): GERARD E. MARABLE(FATHER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1232 YOUNG CT. BALTIMORE, MARYLAND 21202

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): VOSHEEL CEMETERY
Date: 8-18-99
20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: ▶ Doretha Hector CFSP
22. Name and Address of Facility: PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Contact Gunshot Wound of Head
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☒ Yes 2 ☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner? ☒ Yes 2 ☐ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient ☒ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☐ Natural 2 ☐ Accident ☒ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year): 8/10/99
28b. Time of Injury: 1752 M
28c. Injury at Work? 1 ☐ Yes 2 ☒ No
28d. Describe how injury occurred: Suicide shot self
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Residence
28f. Location (Street and Number or Rural Route Number, City or Town, State): 1232 Young Ct. 21201

29a. Certifier (Check only one): 1 ☐ **Certifying Physician**: To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☒ **Medical Examiner:** On the basis of examination and/or investigation, in *my* opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Jan Locke MD
29c. License number: OCME
29d. Date signed (Month, Day, Year): AUGUST 11, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. LAWN LOCKE MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): AUG 17 1999
32. Registrar's Signature: ▶ D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEM #1 PER MD G774 8/20/99 AH

Certificate of Death

Reg. No. 99 25702

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY ~~FRANCIS~~ FRANCES MYERS

2. Date of Death: Month Aug Day 14 Year 99

3. Time of Death: 1502

4a. Facility Name (If not institution, give street and number): Anne Arundel General Hosp

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: AA

Funeral Director

5. Social Security Number: 226-24-4023

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 76 Yrs.

If Under 1 Year: Months ___ Days ___

If Under 24 Hrs.: Hours ___ Min. ___

8. Date of Birth (Month, Day, Year): Sept. 14, 1922

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Annapolis

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2319 Hickory Road

10f. Zip Code: 21401

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cafeteria Manager

16b. Kind of Business/Industry: Anne Arundel County Public Schools

17. Father's Name (First, Middle, Last): Daniel Rufus Aylor

18. Mother's Name (First, Middle, Maiden Surname): Lucy Caroline Hawkins

19a. Informant's Name/Relationship (Type, Print): Hilda F.Whittington (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 717 Appomattox Rd, Davidsonville, MD 21035

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Oak Grove UMC Cemetery

Date: 08/19

20c. Location - City or Town, State: Aylor, Virginia

21. Signature of Funeral Service Licensee: Kenneth S Bare

22. Name and Address of Facility: Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic Heart Disease — UNK

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ___

Due to (or as a consequence of):

c. ___

Due to (or as a consequence of):

d. ___

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one) Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: William P. Jones MD Deputy

29c. License number: D 06054

29d. Date signed (Month, Day, Year): 8/15/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William P. Jones, MD 695 America 21035

State Registrar

31. Date filed (Month, Day, Year): AUG 17 1999

32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25703

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): PAUL MYERS
2. Date of Death: Month AUGUST Dey 14 Year 1999
3. Time of Death: 8:37 PM
4a. Facility Name (If not institution, give street and number): HARBOR HOSPITAL CENTER
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-66-9197
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 44 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 28 1955
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.
10b. County: n/a
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1314 William Street
10f. Zip Code: 21230
10g. Citizen of What Country: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Truck Driver
16b. Kind of Business/Industry: Middle and Meade Company

17. Father's Name (First, Middle, Last): Bernard W. Myers
18. Mother's Name (First, Middle, Maiden Surname): Evelyn L. Bartrug

19a. Informant's Name/Relationship (Type, Print): Dena I. Myers (Husband)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1314 William Street, Baltimore, Md. 21230

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Hill Cemetery
Date: 8/20/99
20c. Location - City or Town, State: Brooklyn Park, Md.

21. Signature of Funeral Service Licensee: David A. Hayes
22. Name and Address of Facility: McCully-Polynaik Funeral Home P.A. 130 E. Fort Ave., Baltimore, Md. 21230

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line.

		Approximate Interval Between Onset end Death
Immediete Cause (Final disease or condition resulting in deeth) a.	SEPTICEMIA	1 DAY
Due to (or as a consequence of): b.	ADULT RESPIRATORY DISTRESS SYNDROME	1 DAY.
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.: CROHN DISEASE

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of ceuse of death? 1 [X] Yes 2 [ ] No

25. Was cese referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Sulcide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and piece, end due to the cause(s) and manner es stated. 2 [ ] **Medical Examiner:** On the besis of exemination end/or investigation, in my opinion, death occurred at the time, dete and piece, snd due to the ceuse(s) and manner stated.
29b. Signature and title of certifier: Shyam RESIDENT
29c. License number: P 12797
29d. Date signed (Month, Day, Year): AUGUST 14, 1999

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): SHWE MRA GYAW 3001 SOUTH HANOVER STREET BALTIMORE MD 21225

State Registrar

31. Date filed (Month, Day, Year): AUG 17 1999
32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND #23 PRT. 1&2 PER MD. G776 10-28-99 J.A.
AMENDED ITEM #8, #10f, #16a PER FH G774 8/24/99 AH

Certificate of Death

Reg. No. 99 25704

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MELVIN MINCEY

2. Date of Death: Month AUG Day 13 Year 1999

3. Time of Death: 9:50 Am

4a. Facility Name (If not institution, give street and number): 7803 GAYWOOD CIRCLE

4b. City, Town, or Location of Death: RANDALLSTOWN

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 216-28-9721

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 68 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 01-14-~~99~~1931

9. Birthplace (State or Foreign Country): EMPORIA, VA

Usual Residence of Decedent

10a. State: MD

10b. County: BALTIMORE

10c. City, Town or Location: RANDALLSTOWN, MD

10d. Inside City Limits: 1 [ ] Yes [X] No

10e. Street and Number: 7803 GAYWOOD CIRCLE

10f. Zip Code: ~~21144~~ 21244

10g. Citizen of What Country? U.S.A.

11. Meritat Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify: X

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 6

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ~~SELF EMPLOYED~~ ROADWAY

16b. Kind of Business/Industry: TRUCK DRIVER

17. Father's Name (First, Middle, Last): MORGAN MINCEY

18. Mother's Name (First, Middle, Maiden Surname): ELSIE BROOKS

19a. Informant's Name/Relationship (Type, Print): DAVID MINCEY, SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9711 KERRINGAN COURT, RANDALLSTOWN, MD 2113

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): WOODLAWN CEMETERY

Date: 8-18-99

20c. Location - City or Town, State: BALTIMORE, COUNTY

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: HOWELL FUNERAL HOME 4600 LIBERTY HGHTS AVE, BALTO. MD 21207

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CRYPTOGENIC CIRRHOSIS ~~Liver Failure~~ — 1 yr

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Kidney Failure

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature], MD

29c. License number: D 27310

29d. Date signed (Month, Day, Year): 8/16/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jeffry N. Posner, MD 1838 Green Tree Rd, Baltimore MD 21208

State Registrar

31. Date filed (Month, Day, Year): AUG 17 1999

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

99-4704-510
crn
Louise Miles

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25705

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Louise May Miles
2. Date of Death (Month, Day, Year): August 14, 1999
3. Time of Death: 2:05 P.M.
4e. Facility Name (If not institution, give street and number): Johns Hopkins Bayview Medical Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-18-3172
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 10, 1925
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Baltimore Highlands
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2767 Norfen Road
10f. Zip Code: 21227
10g. Citizen of What Country?: United States
11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home
17. Father's Name (First, Middle, Last): Frederick Bouchard
18. Mother's Name (First, Middle, Maiden Surname): Dolores Starr
19a. Informent's Name/Relationship (Type, Print): Joanne Fisher (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2669 Thornbrook Road Ellicott City, MD 21042
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Hill Cemetery
Date: 08/18/99
20c. Location - City or Town, State: Brooklyn Park, MD
21. Signature of Funeral Service Licensee
22. Name and Address of Facility: Ambrose Funeral Home of Lansdowne, 2719 Hammonds Ferry Road Lansdowne, MD 21227

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Smoke Inhalation
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hypertensive atherosclerotic Cardiovascular disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year): 8-14-99
28b. Time of Injury: 0125 M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: House fire
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Home
28f. Location (Street and Number or Rural Route Number, City or Town, State): 2767 Norfen Rd. Halethorpe

29a. Certifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): August 15, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): AUG 17 1999
32. Registrar's Signature: Irma D. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

AA10

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25706

MCGINLEY, JOSEPH

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joseph Bonbrake McGinley, Sr.
2. Date of Death: Month AUGUST Day 15, Year 1999
3. Time of Death: 12:15 A.M.
4a. Facility Name (If not institution, give street and number): Berlin Nursing & Rehabilitation Center
4b. City, Town, or Location of Death: Berlin
4c. County of Death: Worcester

Funeral Director

5. Social Security Number: 213-20-3370
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 76 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 02 1922
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD.
10b. County: Worcester
10c. City, Town or Location: Pocomoke City
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 2326 Klej Grange Rd.
10f. Zip Code: 21851
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII/Korean
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Custodian
16b. Kind of Business/Industry: Balt. Co. Board Of Ed.

17. Father's Name (First, Middle, Last): Joseph Keepers McGinley
18. Mother's Name (First, Middle, Maiden Surname): Belle Rouzer Bonbrake

19a. Informsnt's Name/Relationship (Type, Print): Mr. Joseph B. McGinley, Jr./Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2326 Klej Grange Rd. Pocomoke City, MD. 21851

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Dulaney Valley Mem. Gdns.
Date: 8-18-99
20c. Location - City or Town, State: Timonium, MD.

21. Signature of Funeral Service Licensee: Ruth J. Fogle
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, MD. 21204

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. END STAGE RENAL DISEASE
Due to (or as a consequence of):
b. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. CONGESTIVE Heart Failure
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 [ ] **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: D46257
29d. Date signed (Month, Day, Year): AUGUST 15, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 9714 Heathway Drive. Berlin, MD 21811 410-641-4400

State Registrar

31. Date filed (Month, Day, Year): AUG 17 1999
32. Registrar's Signature: [signature] G. Sparks

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

ORIGINAL

WRC
99-4709-510
RONDA
McCOY

AMEND ITEMS: #23 PART I, 27, 28A-F PER MEO G774 99 WR 8-21

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25707

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ronda Marie McCoy
2. Date of Death (Month, Day, Year): AUGUST 14, 1999
3. Time of Death: 6:22 PM.
4a. Facility Name (If not institution, give street and number): ST. AGNES HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death:

Funeral Director

5. Social Security Number: 214-15-5664
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 19 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan.16, 1980
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 502 Sunset Road
10f. Zip Code: 21223
10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Dancer
16b. Kind of Business/Industry: Entertainment

17. Father's Name (First, Middle, Last): Corbet L. McCoy
18. Mother's Name (First, Middle, Maiden Surname): Cecelia Doering

19a. Informant's Name/Reletionship (Type, Print): Cecelia McCoy, Mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 502 Sunset Road, Baltimore, Maryland 21223

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Louden Park Cemetery
Date: 8-18-99
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: Ambrose Funeral Home, 1328 Sulphur Spring Rd., Arbutus, MD 21227

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. NARCOTIC AND COCAINE INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☐ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☒ Could not be determined
28a. Date of Injury (Month, Day Year): 8-14-99
28b. Time of Injury: 5:33 P M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: SUBJECT INGESTED NARCOTIC AND COCAINE
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): PRIVATE DWELLING
28f. Location (Street and Number or Rural Route Number, City or Town, State): 1000 ARION PARK, BALTIMORE, MD

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): AUGUST 15, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): AUG 17 1999
32. Registrar's Signature: Renee G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25708

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WILLIAM A. MATTHEWS JR.

2. Date of Death (Month, Day, Year): AUG. 11 1999

3. Time of Death: 11:00 AM

4a. Facility Name (If not institution, give street and number): BLAKEHURST HEALTH CENTER

4b. City, Town, or Location of Death: TOWSON

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 213-10-2520

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 10/29/1910

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD

10b. County: BALTIMORE

10c. City, Town or Location: TOWSON

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 1055 WEST JOPPA RD.

10f. Zip Code: 21204

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 2YRS

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SALES MANAGER

16b. Kind of Business/Industry: PAPER BOX CO.

17. Father's Name (First, Middle, Last): WILLIAM A. MATTHEWS

18. Mother's Name (First, Middle, Maiden Surname): BERTHA M. LEE

19a. Informant's Name/Relationship (Type, Print): LOUISE K. JOHNSON MATTHEWS

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1055 WEST JOPPA RD. TOWSON, MD. 21204.

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): LORRAINE PARK Date: 08/12/99

20c. Location - City or Town, State: BALTO., MD.

21. Signature of Funeral Service Licensee: William L. Jenkins III

22. Name and Address of Facility: HENRY W. JENKINS & SONS CO. 4905 YORK RD. BALTO., MD. 21212.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia — 13 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Arterial Embolism to the Left Leg, Atrial Fibrillation

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D33897

29d. Date signed (Month, Day, Year): 8/11/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ROBERT J. VISSING M.D. 4300 N. CHARLES ST. BALTO, MD. 21218.

State Registrar

31. Date filed (Month, Day, Year): AUG 17 1999

32. Registrar's Signature: Peggy D. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

99-4690=005
DDG
WILLIAM C McGINNIS

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

MEO GZ75 9-2-99 WR

AMEND ITEMS: #23 PART I, 27, 28A-F, 16A PER

Certificate of Death

99 25709
Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William G. McGinnis, JR.
2. Date of Death Month: AUGUST Day: 13, Year: 1999
3. Time of Death: 1415 PM
4a. Facility Name (If not institution, give street and number): 1385 DEANWOOD ROAD
4b. City, Town, or Location of Death: TOWSON
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 217-64-3808
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 44 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 19, 1955
9. Birthplace (State or Foreign Country): MARYland

Usual Residence of Decedent

10a. State: MARYland
10b. County: BALTIMORE
10c. City, Town or Location: TOWSON
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 1385 Deanwood Road
10f. Zip Code: 21234
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1976-1981
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CLERK ELECTRONICS TECH.
16b. Kind of Business/Industry: SCOTTIES Convenient Foods

17. Father's Name (First, Middle, Last): William G. McGinnis, SR.
18. Mother's Name (First, Middle, Maiden Surname): MARIE McNeil

19a. Informant's Name/Relationship (Type, Print): Linda A. McGinnis
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1385 Deanwood Rd. Balto. Md. 21234

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Md. Veterans Cem. Date: 8/20/99
20c. Location - City or Town, State: Garrison, Md.
21. Signature of Funeral Service Licensee: Gloria Adams Jones
22. Name and Address of Facility: MARSHALL W. JONES, JR. F.H.P.A. 4101 Edmondson Ave. Balto. Md. 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. COCAINE, NARCOTIC AND ALCOHOL INTOXICATION
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? ☒ Yes 2 ☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) SCENE

27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☒ Could not be determined
28a. Date of Injury (Month, Day Year): FOUND: 8-13-99
28b. Time of Injury: FOUND: 2:00 P M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred: UNKNOWN
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): FOUND AT HOME
28f. Location (Street and Number or Rural Route Number, City or Town, State): 1385 DEANWOOD ROAD. BALTIMORE, CO., MD.

29a. Certifier (Check only one): 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): AUGUST 14, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David R Fowler 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): AUG 17 1999
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25710

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jennie Nelson

2. Date of Death (Month, Day, Year): August 12, 1999

3. Time of Death: 5:30 am

4a. Facility Name (If not institution, give street and number): Future Care Nursing Home

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 578-38-4916

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 8, 1913

9. Birthplace (State or Foreign Country): SC

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore City

10c. City, Town or Location: Baltimore City

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2700 North Charles Street

10f. Zip Code: 21218

10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Educator

16b. Kind of Business/Industry: Education

17. Father's Name (First, Middle, Last): Harry Richard Howze, Sr,

18. Mother's Name (First, Middle, Meiden Surname): Nora Johnson

19a. Informant's Name/Relationship (Type, Print): Warren J. Howze / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1190 West Northern Parkway Baltimore MD 21200

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Hillside Memorial Park | Date: August 17, 1999

20c. Location - City or Town, State: Sumter, SC

21. Signature of Funeral Service Licensee: Victor P. Doda, Jr.

22. Name and Address of Facility: Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heert failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel diseese or condition resulting in death)

a. Dementia of the Alzheimer type — 9 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Protein energy malnutrition

Immobility syndrome

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☑ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end plece, end due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, deeth occurred et the time, dete end place, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier: J Boston MD

29c. License number: D28462

29d. Date signed (Month, Day, Year): August 12, 1999

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): J Boston FutureCare Homewood 2700N Charles Street

State Registrar

31. Dete filed (Month, Day, Year): AUG 17 1999

32. Registrar's Signature: Barbara G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25711

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Marcella Eskridge Olsen
2. Date of Death (Month, Day, Year): AUG 16, 1999
3. Time of Death: 3:45 AM

4a. Facility Name (If not institution, give street and number): 8913 56th Avenue
4b. City, Town, or Location of Death: Berwyn Heights
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 579-14-2605
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JAN 16, 1922
9. Birthplace (State or Foreign Country): District of Columbia

Usual Residence of Decedent

10a. State: MD
10b. County: Prince Georges
10c. City, Town or Location: Berwyn Heights
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 8913 56th Avenue
10f. Zip Code: 20740
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Accounting Clerk
16b. Kind of Business/Industry: U.S. Government

17. Father's Name (First, Middle, Last): Vernon Eskridge
18. Mother's Neme (First, Middle, Maiden Surname): Frances McAndrews

19a. Informant's Name/Relationship (Type, Print): Frances Kunsman/daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 40 Barrington Place Bel Air, MD 21014

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory, Inc. Date: 08/16/99
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: George E. MacNabb
22. Neme end Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. METASTATIC BRONCHOGENIC CARCINOMA — 11 MONTHS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or es a consequence of):
c. Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: CHRONIC OBSTRUCTIVE AIRWAY DISEASE.

23b. Did tobecco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D22910
29d. Date signed (Month, Day, Year): August 16, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ASIF S. QADRI, 4700 BERWYN HOUSE RD COLLEGE PARK MD 20740

State Registrar

31. Date filed (Month, Day, Year): AUG 17 1999
32. Registrar's Signature: Irma G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25712

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Eula Pearl Pritchard

2. Date of Death (Month, Day, Year): August 13, 1999

3. Time of Death: 10:05 pm

4a. Facility Name (If not institution, give street and number): 1101 Old Eastern Avenue "Apt A"

4b. City, Town, or Location of Death: Essex

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 241 42 1571

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 67 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 28, 1931

9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Essex

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1101 Old Eastern Avenue "Apt A"

10f. Zip Code: 21221

10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 | College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Manager

16b. Kind of Business/Industry: Restaurant

17. Father's Name (First, Middle, Last): George Leonard Benson

18. Mother's Neme (First, Middle, Maiden Surname): Mozelle Hogg

19a. Informant's Name/Relationship (Type, Print): Bruce Wayne Haire (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 8105 Sea Water Path Columbia, Md. 21045

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donation 5☐ Other (Specify)

20b. Piece of Disposition (Name of cemetery, cremetory or other place): Oak Lawn Cemetery | Date: 8/17/1999

20c. Location - City or Town, Stete: Baltimore, Md.

21. Signature of Funeral Service Licensee: ▶ John W. Burkowske

22. Name end Address of Facility: Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on eech line.

Approximete Interval Between Onset and Death

Immediete Cause (Finel disease or condition resulting in death)

a. Metastatic Kidney cancer

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medicat examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date and piece, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: ▶ Larry Waterbury, M.D.

29c. License number: DO 9559

29d. Date signed (Month, Day, Year): 8/16/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): LARRY WATERBURY, M.D. JHBMC, 4940 EASTERN AVE., BALT., MD. 21224

State Registrar

31. Date filed (Month, Day, Year): AUG 17 1999

32. Registrar's Signature: ▶ B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit copy.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25713

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Gladys Joy Phares

2. Date of Death Month: Aug Day: 15 Year: 99

3. Time of Death: 9:50 pm

4a. Facility Name *(If not institution, give street and number)*: Charlestown Care Center

4b. City, Town, or Location of Death: Catonsville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 312-30-0017

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 87 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: SEP 3, 1911

9. Birthplace *(State or Foreign Country)*: Minnesota

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 709 Maiden Choice Ln., Apt. 6103

10f. Zip Code: 21228

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 4 College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Medical Technician

16b. Kind of Business/Industry: Dr.'s Office

17. Father's Name *(First, Middle, Last)*: Moses Smith

18. Mother's Name *(First, Middle, Maiden Surname)*: Dorthea Thuman

19a. Informant's Name/Relationship *(Type, Print)*: John C. Phares/son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1340 Bruceville Rd. Keymar, MD 21757

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metro Crematory, Inc.

Date: 08/16/99

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Edward A. Gregorchik

22. Name and Address of Facility: Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. End stage Congestive Heart failure — year

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Aortic Stenosis — year

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Andres Salazar MD

29c. License number: D 51051

29d. Date signed *(Month, Day, Year)*: August 16, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Andres Salazar 711 Maiden choice lane, Catonsville, MD, 21228

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 17 1999

32. Registrar's Signature: B. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

NAME: Gladys Phares

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25714

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FRANCIS D. POLK, III.

2. Date of Death — Month: AUGUST Day: 12 Year: 1999

3. Time of Death: 2000

4a. Facility Name (If not institution, give street and number): FALLSTON GENERAL HOSPITAL

4b. City, Town, or Location of Death: FALLSTON

4c. County of Death: HARFORD

Funeral Director

5. Social Security Number: 212-18-8224

6. Sex: ☒ M ☐ F

7. Age (In yrs. last birthday): 78 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JULY 9, 1921

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: HARFORD

10c. City, Town or Location: FOREST HILL

10d. Inside City Limits: ☐ Yes ☒ No

10e. Street and Number: 1900 PHILLIPS MILL ROAD

10f. Zip Code: 21050

10g. Citizen of What Country? U.S.A.

11. Marital Status: ☐ 1 Never Married ☒ 2 Married ☐ 3 Widowed ☐ 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? ☒ 1 Yes ☐ 2 No If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ 1 Yes ☒ 2 No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12YRS.

College (1-4or 5+): 2YRS.

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SELF EMP. - OWNER

16b. Kind of Business/Industry: DEVEREUX LTD.

17. Father's Name (First, Middle, Last): FRANCIS D. POLK, JR.

18. Mother's Name (First, Middle, Maiden Surname): MARGARET ROSE

19a. Informant's Name/Relationship (Type, Print): ANNEMARIE H. POLK

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1900 PHILLIPS MILL ROAD FOREST HILL MARYLAND 21050

20a. Method of Disposition: ☒ 1 Burial ☐ 2 Cremation ☐ 3 Removal from State ☐ 4 Donation ☐ 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): DRUID RIDGE CEMETERY

Date: AUG. 16 1999

20c. Location - City or Town, State: PIKESVILLE, MARYLAND

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: EVANS FUNERAL CHAPEL - BEL AIR, P.A. 21050 3 NEWPORT DRIVE FOREST HILL, MARYLAND

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. DIFFUSE LARGE CELL LYMPHOMA — 8 MONTHS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

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23b. Did tobacco use contribute to the cause of death? ☐ 1 Yes ☒ 2 No ☐ 3 Probably ☐ 4 Unknown

24a. Was an autopsy performed? ☐ 1 Yes ☒ 2 No

24b. Were autopsy findings available prior to completion of cause of death? ☐ 1 Yes ☐ 2 No

25. Was case referred to medical examiner? ☐ 1 Yes ☒ 2 No

26. Place of Death (Check only one)

Hospital: ☒ 1 Inpatient ☐ 2 ER/Outpatient ☐ 3 DOA

Other: ☐ 4 Nursing Home ☐ 5 Residence ☐ 6 Other (Specify)

27. Manner of Death: ☒ 1 Natural ☐ 2 Accident ☐ 3 Suicide ☐ 4 Homicide ☐ 5 Pending investigation ☐ 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? ☐ 1 Yes ☐ 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): ☒ 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D 31775

29d. Date signed (Month, Day, Year): AUGUST 12, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOAN P. EDWARDS, M.D. 2113 BEL AIR ROAD FALLSTON, MARYLAND 21047

State Registrar

31. Date filed (Month, Day, Year): AUG 17 1999

32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

POLK, FRANCIS D. III

18

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25715

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Albert Retowsky

2. Date of Death: Month August Day 15 Year 1999

3. Time of Death: 2:15 P.M.

4a. Facility Name (If not institution, give street and number): 160 Ryan Road

4b. City, Town, or Location of Death: Pasadena

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 212-18-9088

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): SEP 9, 1921

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Pasadena

10d. Inside City Limits: 1 [ ] Yes [X] No

10e. Street and Number: 160 Ryan Road

10f. Zip Code: 21122

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yeer or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [ ] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Salesman

16b. Kind of Business/Industry: Retail

17. Father's Nema (First, Middle, Last): Herbert Retowsky

18. Mother's Nama (First, Middle, Maiden Surnama): Alma Clayland

19a. Informent's Name/Reletionship (Type, Print): Mary Retowsky/wife

19b. Mailing Address (Street and Number or Rurat Route Number, City or Town, State, Zip Code): 160 Ryan Rd. Pasadena, MD 21122

20a. Method of Disposition: 1 [ ] Buriel 2 [X] Cremetion 3 [ ] Removal from Stete 4 [ ] Donetion 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Metro Crematory, Inc. Date: 08/16/99

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Edward A. Gregorchik

22. Name and Address of Facility: Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heert failure. List only one causa on aach lina.

Approximeta Intervel Between Onset end Death

Immedieta Cause (Finel disease or condition resulting in death): e. Malignant Fibrous Histiocytoma — 1 Month

Due to (or as a consequence of):

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in death) Last

b. Due to (or es e consequence of):

c. Due to (or es e consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobecco use contribute to the causa of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Wes en autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Wara autopsy findings aveilable prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only ona): Hospitel: 1 [ ] Inpatiant 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Homa 5 [✓] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigetion 6 [ ] Could not be determined

28a. Data of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At homa, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rurat Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [✓] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier: Gnanaraj M.D.

29c. License number: D39505

29d. Date signed (Month, Day, Year): August 16, 1999

30. Name end address of person who completed cause of death (Item 23a) (Type, Print): Yudhishtra Manikam 1600 Crain Hwy, Glen Burnie, MD. 21061

State Registrar

31. Dete filed (Month, Day, Year): AUG 17 1999

32. Registrar's Signatura: Lisa G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25716

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Stella Virginia Roza

2. Date of Death (Month, Day, Year): AUG 14, 1999

3. Time of Death: 8:45 PM

4a. Facility Name (If not institution, give street and number): Cromwell Nursing Center Genesis Eldercare

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-07-9063

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): DEC 10, 1919

9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 8710 Emge Road

10f. Zip Code: 21234

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Meat Wrapper

16b. Kind of Business/Industry: Grocery Store

17. Father's Name (First, Middle, Last): David Moore

18. Mother's Name (First, Middle, Maiden Surname): Mary Olive Cross

19a. Informant's Name/Relationship (Type, Print): Thomas L. Oakley/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4301 Belmar Ave. Overlea, MD 21206

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory, Inc. Date: 08/16/99

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Edward A. Gregorchik

22. Name and Address of Facility: Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Arteriosclerotic coronary artery Disease	one yr.
Due to (or as a consequence of): b.	Diabetes Mellitus	2 yr.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Renal failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Marvin Kanschuter MD

29c. License number: D21022

29d. Date signed (Month, Day, Year): 8-16-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 8114 SANDPIPER CIRCLE BALTO. MD 21236

State Registrar

31. Date filed (Month, Day, Year): AUG 17 1999

32. Registrar's Signature: Irma G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28d show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25717

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Virginia J. Riegel
2. Date of Death Month Day Year: August 16, 1999
3. Time of Death: 12:03AM
4a. Facility Name *(If not institution, give street and number)*: Franklin Square Hospital Center
4b. City, Town, or Location of Death: Rosedale
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 218-22-3131
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 73 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: May 8, 1926
9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2701 Gray Manor Terr.
10f. Zip Code: 21222
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Messenger
16b. Kind of Business/Industry: County Government

17. Father's Name *(First, Middle, Last)*: Thomas E. Fitch
18. Mother's Name *(First, Middle, Maiden Surname)*: Mary E. McLean

19a. Informant's Name/Relationship *(Type, Print)*: Bernard Riegel /son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7915 Shore Rd Baltimore, MD 21219

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Oak Lawn Cemetery
Date: Aug 19 1999
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Anthony C. Connelly
22. Name and Address of Facility: Connelly Funeral Home of Dundalk 7110 Sollers Point Rd 21222

Riegel, Virginia
Baltimore, Maryland 21215-0020

permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Renal Failure	2 Years
Due to (or as a consequence of): b.	Diabetes Melitis	10 Years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hypertension, Anemia, Cellulitis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D 186494
29d. Date signed *(Month, Day, Year)*: August 16 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr Anthony Samphilipo 9000 Franklin Square Drive Baltimore, MD 21237

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 17 1999
32. Registrar's Signature: Geraldine D. Sparks

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25718

Certificate of Death Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Vincent SHEPPERSON
2. Date of Death Month: AUG. Day: 11 Year: 1999
3. Time of Death: 9:10pm
4a. Facility Name *(If not institution, give street and number)*: LONG GREEN NURSING CENTER
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: NA

Funeral Director

5. Social Security Number: 212-84-9546
6. Sex: 1☐M 2☑F
7. Age *(In yrs. last birthday)*: 37 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 02-09-62
9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 325 East 20th Street
10f. Zip Code: 21218
10g. Citizen of What Country?: USA

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces?: 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th Grade; College (1-4or 5+): NA
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Forklift Operator
16b. Kind of Business/Industry: Company

17. Father's Name *(First, Middle, Last)*: James S. Shepperson
18. Mother's Name *(First, Middle, Maiden Surname)*: Gladys E. Morton

19a. Informant's Name/Relationship *(Type, Print)*: Douglas W. Shepperson
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 938 Webb Court Baltimore, Maryland 21202

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Voshell Mem. Gardens
Date: 08-18-99
20c. Location - City or Town, State: Dundalk, MD

21. Signature of Funeral Service Licensee: Debra M. Davis
22. Name and Address of Facility: Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e.	Failure to Thrive	weeks
Due to (or as a consequence of): b.	HIV Encephalopathy	months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last. Due to (or as a consequence of): c.	HIV Infection	years
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Nephropathy
Candida Esophagitis

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D17118
29d. Date signed *(Month, Day, Year)*: 8/12/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Paul Schwartz M.D. 115 E. Melrose Ave 21212

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 17 1999
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

99-4737-005
crn
Kenneth Michael Schultz

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25719

AMEND ITEMS: #23 PART I, II, 27, 28A-F PER MEO G774 8-26 WR

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Kenneth Michael Schultz
2. Date of Death (Month, Day, Year): August 16, 1999
3. Time of Death: 1:10 A.M.
4a. Facility Name (If not institution, give street and number): 2208 Silver Lane
4b. City, Town, or Location of Death: Middle River
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216 86 7906
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 36 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 28, 1963
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Essex
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2001 Silver Lane
10f. Zip Code: 21221
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1983
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Tow Truck Operator
16b. Kind of Business/Industry: Automotive

17. Father's Name (First, Middle, Last): Maurice E. Schultz
18. Mother's Name (First, Middle, Maiden Surname): Irene D. Rajewski

19a. Informant's Name/Relationship (Type, Print): Maurice E. Schultz (Father)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2001 Silver Lane Baltimore, Md. 21221

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): Greenmount Crematory — Date: 8/17/1999
20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: John W. Burkowske
22. Name and Address of Facility: Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. AMITRIPTYLINE INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☒ Could not be determined
28a. Date of Injury (Month, Day Year): Found: 8-16-99
28b. Time of Injury: UNKNOWN M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: UNKNOWN
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): HOME
28f. Location (Street and Number or Rural Route Number, City or Town, State): 2208 SILVER LANE, MIDDLE RIVER, MD

29a. Certifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): August 16, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. Alton Hicks MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): AUG 17 1999
32. Registrar's Signature: Donna D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEM #1 PER MD G774 8/24/99 AH

Certificate of Death

Reg. No. 99 25720

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ~~SCHERER, CHARLES~~ CHARLES SCHERER

2. Date of Death: Month 08 Day 13 Year 99

3. Time of Death: 14:32

4a. Facility Name (If not institution, give street and number): ST AGNES HEALTHCARE

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-28-2948

6. Sex: 1 X M 2 F

7. Age (In yrs. last birthday): 68 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 12-12-30

9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD.

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 X Yes 2 No

10a. Street and Number: 3311 ELGIN AVE. 2nd FLOOR

10f. Zip Code: 21216

10g. Citizen of What Country?: USA

11. Marital Status: 1 Never Married 2 Married 3 Widowed 4 X Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): -12- | College (1-4or 5+): -0-

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): TRUCK DRIVER

16b. Kind of Business/Industry: DISTRIBUTION

17. Father's Name (First, Middle, Last): CHARLES S. SCHERER SR.

18. Mother's Name (First, Middle, Maiden Surname): MABLE CURTIS

19a. Informant's Name/Relationship (Type, Print): BELINDA SMITH(DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 202 RED BUD ROAD EDGEWOOD, MD. 21040

20a. Method of Disposition: 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): METRO CREMATORY

Date: 8-18-99

20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: Doretha Hector CFSP

22. Name and Address of Facility: PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ASPIRATION PNEUMONIA — 7hours

Due to (or as a consequence of):

b. BILATERAL CVA IN COMA — 8 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 X No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 X No

25. Was case referred to medical examiner? 1 Yes 2 X No

26. Place of Death (Check only one): Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA | Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death: 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 8 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D26256

29d. Date signed (Month, Day, Year): 08/13/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR BARIFI OPARE-ADDO 2502 W. PATAPSCO 2B BALTIMORE MD 21230

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

NAME SCHERER, CHARLES

State Registrar

31. Date filed (Month, Day, Year): AUG 17 1999

32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25721

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Herman Stuger
2. Date of Death: Month August Day 14 Year 1999
3. Time of Death: 9:40 a.m.
4a. Facility Name (If not institution, give street and number): 6026 Berkeley Avenue
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: MD.

Funeral Director

5. Social Security Number: 061-24-0267
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 76 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 22, 1922
9. Birthplace (State or Foreign Country): South America

Usual Residence of Decedent

10a. State: MD.
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 6026 Berkeley Avenue
10f. Zip Code: 21209
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 1☐ Yes 2☒ No Specify:
14. Reca - American Indian, Black, White, atc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired): Marine Engineer
16b. Kind of Business/Industry: MEBA

17. Father's Nama (First, Middle, Last): Sigamar Stuger
18. Mother's Nama (First, Middle, Maiden Sumama): Marie Dalhberg

19a. Informant's Name/Relationship (Type, Print): Ella H. Stuger Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda): 6026 Berkeley Avenue Baltimore, MD. 21209

20a. Mathod of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removat from Stata 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Nama of cemetery, crematory or other place): Metro Crematory
Data: Aug. 16
20c. Location - City or Town, State: Baltimore, MD.

21. Signeture of Funeral Service Licensee: ▶ Herbert E. Nutter
22. Nama and Address of Facility: Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Balto. MD. 21216

Physician /Medical Examiner

23a. Part1. Enter tha disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one cause on aech line.

Approximata Intarval Batween Onset end Daath

Immediata Causa (Final diseasa or condition resulting in death): a. Metastatic cancer Pancreas. — Due to (or as a consequence of): — More than 2yrs.

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. — Due to (or as a consequence of):
c. — Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No
24b. Wara autopsy findings availeble prior to completion of causa of death? 1☐ Yes 2☒ No

25. Wes casa refarred to medicat examiner? 1☐ Yas 2☒ No

26. Place of Daath (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Homa 5☒ Residence 6☐ Othar (Specify)

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Data of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end dua to tha cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at tha tima, data and place, and dua to the cause(s) and manner stated.

29b. Signatura and title of certifier: ▶ Sureesh Tripuraneni
29c. License number: D 30661
29d. Date signed (Month, Day, Year): August 16th 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SIREESH TRIPURANENI 5601 Loch Raven Blvd. Baltimore, Md-21239.

State Registrar

31. Data filed (Month, Day, Year): AUG 17 1999
32. Registrar's Signature: ▶ Brenda B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

MD CATE

476

99-4591-510
B.K.S

BERNARD SMITH
Amended Item#14 perFH G774 8/17/99 EW

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25722

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Bernard Smith
2. Date of Death Month Day Year: AUG. 6, 1999
3. Time of Death: 2239
4a. Facility Name (If not institution, give street and number): 3600 WEST BELVEDERE AVENUE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 276-46-2489
6. Sex: XX 1 M 2 F
7. Age (In yrs. last birthday): 53 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 1, 1945
9. Birthplace (State or Foreign Country): OH

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore City
10d. Inside City Limits: XX 1 Yes 2 No
10e. Street and Number: 3600 West Belvedere Avenue
10f. Zip Code: 21215
10g. Citizen of What Country? United States

11. Marital Status: 1 Never Married 2 XX Married 3 Widowed 4 Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XX No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 XX No Specify:
14. Race - American Indian, Black, White, etc. Specify: ~~White~~ BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Technician
16b. Kind of Business/Industry: Health Care

17. Father's Name (First, Middle, Last): James Joseph Smith
18. Mother's Name (First, Middle, Maiden Surname): Willie Mae Jones

19a. Informant's Name/Relationship (Type, Print): Richard Smith / Brother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 663 Kinsman N.W. Warren, OH 44483

20a. Method of Disposition: 1 Burial 2 Cremation 3 XX Removal from State 4 Donation 5 Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Western Reserve Cemetery | Date: August 17, 1999
20c. Location - City or Town, State: Warren, OH

21. Signature of Funeral Service Licensee: Victor P. Doda, Jr.
22. Name and Address of Facility: Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Multiple Blunt and
Due to (or as a consequence of):
b. Sharp Force Injuries

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 XX No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 XX Yes 2 No
24b. Were autopsy findings available prior to completion of cause of death? 1 XX Yes 2 No

25. Was case referred to medical examiner? XX Yes 2 No

26. Place of Death (Check only one): Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA | Other: 4 Nursing Home XX Residence 6 Other (Specify)

27. Manner of Death: 1 Natural 2 Accident 3 Suicide 4 XX Homicide 5 Pending Investigation 6 Could not be determined

28a. Date of Injury (Month, Day, Year): 8/6/99
28b. Time of Injury: 2238 M Approx
28c. Injury at Work? 1 Yes 2 XX No
28d. Describe how injury occurred: Subject Assaulted.
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Home; 3600 Belvedere Ave;
28f. Location (Street and Number or Rural Route Number, City or Town, State): Baltimore, Md.

29a. Certifier (Check only one): 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. XX Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J. Pestaner M.D.
29c. License number: O.C.M.E
29d. Date signed (Month, Day, Year): AUG. 7, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): AUG 17 1999
32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25723

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ANDREW SREBROSKI SR.

2. Date of Death (Month, Day, Year): AUGUST 15 1999

3. Time of Death: 1:25 AM

4a. Facility Name (If not institution, give street and number): MARINER HEALTH OF GLEN BURNIE

4b. City, Town, or Location of Death: GLEN BURNIE

4c. County of Death: ANNE ARUNDEL CO.

Funeral Director

5. Social Security Number: 188-05-1303

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 86 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 20 1913

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.

10b. County: n/a

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 3437 6th Street

10f. Zip Code: 21225

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 6

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa ratired): Shipyard Superintented

16b. Kind of Business/Industry: Boston Metals Co.

17. Father's Name (First, Middle, Last): Joseph Srebroski

18. Mothar's Name (First, Middle, Malden Sumame): Alexandria Gogal

19a. Informant's Name/Relationship (Type, Print): Andrew Srebroski, Jr. (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3437 6th Street, Baltimore, Md. 21225

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Holy Cross Cemetery

Date: 8/19/99

20c. Location - City or Town, State: Brooklyn Park, Md.

21. Signature of Funeral Service Licensee: Daniel A Mayb

22. Name and Address of Facility: McCully-Polyniak Funeral Home P.A. 237 E. Patapsco Ave., Baltimore, Md. 21225

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pagas 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the moda of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each lina.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. RESPIRATORY FAILURE — 1 DAY

Due to (or as a consequance of):

b. ASPIRATION PNEUMONIA — 1 DAY

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or es a consequenca of):

c. CEREBRO VASCULAR DISEASE — 2 YEARS

Dua to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Ware autopsy findings available prior to complation of cause of death? 1 [ ] Yes 2 [X] No

25. Was case refarred to medical examiner? 1 [ ] Yas 2 [X] No

26. Place of Death (Check only ona)

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Othar: 4 [X] Nursing Home 5 [ ] Residenca 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicida 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Dascribe how Injury occurred

28a. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end placa, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examinar:** On tha basis of axamination and/or invastigation, in my opinion, death occurred at tha tima, data and place, and dua to the cause(s) and manner stated.

29b. Signature end title of certifier: L. Ruben M.D

29c. Licanse number: D-22609

29d. Date signed (Month, Dey, Yeer): AUGUST 16-1999.

30. Name and address of person who completed cause of daath (Item 23a) (Type, Print): RUBEN-REIGER M.D. 7445 FURNACEBRANCH RD GLEN BURNIE MD 21060

State Registrar

31. Date filed (Month, Day, Year): AUG 17 1999

32. Registrar's Signature: Jenna G. Sparks

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25724

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): SAMUEL J SMITH
2. Date of Death Month: AUG Day: 13 Year: 1999
3. Time of Death: 8 58 A.M.
4a. Facility Name (If not institution, give street and number): BON SECOURS HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 220-30-6829
6. Sex: 1 [X] M 2 [ ] F
7. Age (in yrs. last birthday): 71 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 11-6-27
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1193 N FULTON AVE
10f. Zip Code: 21217
10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, apecify Cuban, Maxican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Rece - American Indian, Bleck, Whita, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 / College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
16b. Kind of Business/Industry

17. Father's Neme (First, Middle, Last): SAMUEL BULL SMITH
18. Mother's Name (First, Middle, Maiden Surneme): CAROLYN CARTER

19a. Informant's Name/Relationship (Type, Print): MICHEAL SMITH (SON)
19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code): 1193 N FULTON AVE

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other piece): WOODLAWN
Data: 8-17-99
20c. Location - City or Town, Stata: BALTO CITY

21. Signature of Funeral Service Licensee: Willie Edwards
22. Name and Address of Facility: HOWELL FUNERAL HOME 4600 LIBERTY HEIGHTS AVE 21207

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart lailura. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediete Causa (Final disease or condition resulting in death)
a. ASPIRATION PNEUMONIA — DAYS
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.
INFECTED DECUBITUS ULCERS
CHRONIC RENAL FAILURE

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yea 2 [X] No 3 [ ] Probably 4 [ ] Unknown
24a. Wes an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No
25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only ona): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yas 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the tima, data and place, and dua to tha causa(s) and mannar as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, daath occurred at the time, date end place, and due to the cause(s) and manner stated.
29b. Signeture and title of certifier: SURJIT JULKA M.D.
29c. License number: D26395
29d. Date signed (Month, Day, Year): 8-13-99
30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): SURJIT JULKA MD 821 N. EUTAW ST. SUITE 407 BALTIMORE MD 21201

State Registrar

31. Dete filed (Month, Day, Year): AUG 17 1999
32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25725

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: WOODROW J. SHEA
2. Date of Death (Month, Day, Year): August 14, 1999
3. Time of Death: 11:00 p.m.
4a. Facility Name *(If not institution, give street and number)*: 976 Chesney Lane
4b. City, Town, or Location of Death: Bel Air
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 131-01-8095
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 81 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Sept. 23, 1917
9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: MD.
10b. County: Harford
10c. City, Town or Location: Bel Air
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 976 Chesney Lane
10f. Zip Code: 21014
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th grade — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Owner
16b. Kind of Business/Industry: Restaurant

17. Father's Name *(First, Middle, Last)*: Dennis Shea
18. Mother's Name *(First, Middle, Maiden Surname)*: Julia Sullivan

19a. Informant's Name/Relationship *(Type, Print)*: Mary A. Shea (Wife)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 976 Chesney Lane, Bel Air, MD. 21014

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Green Mount Crematory
Date: 8/19/99
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Robert J. Schimunek Jr.
22. Name and Address of Facility: Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, MD. 21014

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Metastatic lung Cancer — 6 Mos
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Arthur A Scopick MD
29c. License number: D10091
29d. Date signed *(Month, Day, Year)*: 8/17/99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Arthur A Scopick MD ST Jos Med Cntr Towson, MD 21204

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 17 1999
32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25726

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CLYDE STOKES

2. Date of Death: Month AUGUST Dey 11, Year 1999

3. Time of Death: 15:38

4a. Facility Name (If not institution, give street and number): JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE CITY

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 214-38-1961

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 57 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Year): DEC.6,1941

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 3109 RAVENWOOD AVENUE

10f. Zip Code: 21213

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [ ] No If Yes, Give Year or Dates: X

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: AFRO_AMERICAN

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12TH

College (1-4or 5+): N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LABORER

16b. Kind of Business/Industry: BETHLEHEM STEEL CO.

17. Father's Name (First, Middle, Last): CURTIS H. STOKES, SR.

18. Mother's Name (First, Middle, Maiden Surname): ALICE V. WINKLER

19a. Informant's Name/Relationship (Type, Print): ALICE V. STOKES / MOTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4424 CLAREWAY BALTO, MD. 21213

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): BALTIMORE CEMETERY

Date: AUG.20,1999

20c. Location - City or Town, State: BALTO,MD.

21. Signature of Funeral Service Licensee: Patricia Betts

22. Name and Address of Facility: CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 21213

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ACUTE MYOCARDIAL INFARCTION — 7HOURS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the ceuse(s) and manner steted.

29b. Signature and title of certifier: MD

29c. License number: RES-000

29d. Date signed (Month, Day, Year): August 11, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOHN HAGE MD 2809 BOSTON ST. APT 325 BALTIMORE, MD 21224

State Registrar

31. Date filed (Month, Day, Year): AUG 17 1999

32. Registrar's Signature: Jeanne G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

99-4719-510
mnmr
Maggie May Sessoms

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25727

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Maggie M. Sessoms
2. Dete of Death Month / Dey / Year: August 15, 1999
3. Time of Death: 7:00 a.m.
4e. Facility Name *(If not institution, give street end number)*: 1716 Harlem Avenue
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 238-32-1594
6. Sex: 1☐M 2☒F
7. Age *(In yrs. last birthday)*: 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Day, Year)*: May 29, 1924
9. Birthplace *(State or Foreign Country)*: North Carolina

Usuel Residence of Decedent

10a. Stete: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 1716 Harlem Ave.
10f. Zip Code: 21217
10g. Citizen of What Country?: USA

11. Merital Stetus: 1☐Never Married 2☐Merried 3☒Widowed 4☐Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Yeer or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*
14. Race - American Indian, Bleck, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 12 | College (1-4or 5+): N/A
16a. Decedent's Usuei Occupation *(Give kind of work done duning most of working life. DO NOT use retired)*: Domestic
16b. Kind of Business/Industry: Homes

17. Father's Neme *(First, Middle, Last)*: Archie Walker
18. Mother's Neme *(First, Middle, Maiden Surneme)*: Daisy Walker

19e. Informent's Neme/Relationship *(Type, Print)*: Thomas Walker-Brother
19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 606 Allendale St. Balto. MD 21229

20e. Method of Disposition: 1☒Burial 2☐Cremetion 3☐Removel from Stete 4☐Donation 5☐Other *(Specify)*
20b. Plece of Disposition *(Neme of cemetery, cremetory or other piece)*: Community Cemetery
Dete: 8/21/99
20c. Location - City or Town, Stete: Pender, NC

21. Signature of Funeral Service Licensee: [signature]
22. Neme end Address of Feciliti: Albert P. Wylie F/H, P.A. 638 N. Gilmor St. Balto., MD 21217

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respirefory errest, shock, or heert feilure. List only one cause on eech line. — Approximete Interval Between Onset end Deeth

Immediete Ceuse (Final diseese or condition resulting in deeth)
a. Arteriosclerotic Cardiovascular Disease
Due to (or es a consequence of):
Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in deeth) Lest
b.
Due to (or as e consequence of):
c.
Due fo (or es a consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobecco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24e. Wes an eutopsy performed? Inspection 1☐Yes 2☒No
24b. Were autopsy findings aveilable prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☒Yes 2☐No
26. Plece of Death *(Check only one)*: Hospitel: 1☐Inpetient 2☐ER/Outpetient 3☐DOA | Other: 4☐Nursing Home 5☒Residence 8☐Other *(Specify)*
27. Manner of Death: 1☒Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined
28a. Dete of Injury *(Month, Dey Yeer)*
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and menner as stated. 2☒ **Medical Examiner:** On the besis of exemination and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and menner steted.

29b. Signeture end title of certifier: [signature] A.M. Dixon
29c. License number: O.C.M.E.
29d. Date signed *(Month, Day, Year)*: August 15, 1999
30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print): 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Dey, Yeer): AUG 17 1999
32. Registrer's Signeture: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

A775

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25728

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MAUREEN VANN
2. Date of Death (Month, Day, Year): 08 - 12 - 99
3. Time of Death: 23:38
4a. Facility Name (If not institution, give street and number): SAINT AGNES HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-62-1714
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 46 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 11-24-53
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 1148 ELBANK AVENUE
10f. Zip Code: 21239
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☑ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elamentary/Secondary (0-12): 12 TH GRADE | College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MANAGER
16b. Kind of Business/Industry: FOOD MARKET

17. Father's Name (First, Middle, Last): DANIEL BROWN
18. Mother's Name (First, Middle, Maiden Surname): TINNIE BUMPAS

19a. Informent's Name/Relationship (Type, Print): SHAWN BROWN | SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6617 EBERLE DR. # 303, BALTO. MD. 21215

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): KING MEMORIAL PARK
Date: 8-17-99
20c. Location - City or Town, State: RANDALLSTOWN, MD

21. Signature of Funeral Service Licensee: ▶ Vaughn C Greene
22. Name and Address of Facility: VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL. PIKE, BALTO. MD. 21229

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications thet causad tha death. Do not antar the mode of dying, such es cardiac or respiratory errast, shock, or heart failure. List only ona causa on aach line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finel diseese or condition resulting in death)	a. ACUTE MYOCARDIAL INFARCTION	1½ hours
	Due to (or es a consequenca of):	
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest	b.	
	Due to (or es a consequence of):	
	c.	
	Due to (or es a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

1. RESPIRATORY FAILURE, VENTILATOR DEPENDENT 2° # 2
2. END STAGE MULTIPLE SCLEROSIS
3. CONGESTIVE HEART FAILURE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☑ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Jerome D Snyder MD
29c. License number: D 22648
29d. Date signed (Month, Day, Year): AUGUST 12, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JEROME SNYDER M.D. 900 SOUTH CATON AVENUE BALTIMORE, MARYLAND 21229

State Registrar

31. Date filed (Month, Day, Year): AUG 17 1999
32. Registrar's Signature: ▶ Laura G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

VANN, MAUREEN

2 of 3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25729

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Sandra A. Walker
2. Date of Death (Month, Day, Year): August 14, 99
3. Time of Death: 7:30am
4a. Facility Name (If not institution, give street and number): 2808 Topaz Road
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: NA

Funeral Director

5. Social Security Number: 507-54-8837
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 56 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 09-10-43
9. Birthplace (State or Foreign Country): NE

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 2808 Topaz Road
10f. Zip Code: 21234
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10th Grade | College (1-4or 5+): NA
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife
16b. Kind of Business/Industry: in home

17. Father's Name (First, Middle, Last): James Allen
18. Mother's Name (First, Middle, Maiden Surname): Charlotte Ellis

19a. Informant's Name/Relationship (Type, Print): Martin Walker
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2808 Topaz Road Baltimore, Maryland 21234

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Greenmount Cemetery
Date: 08-19-99
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. BREAST CANCER, METASTATIC — 2 YRS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ G. F. C MD
29c. License number: D27730
29d. Date signed (Month, Day, Year): 8/17/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GARY COHEN, MD 6519 N. CHARLES ST. BALTO. MD. 21204

State Registrar

31. Date filed (Month, Day, Year): AUG 17 1999
32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25730

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FRANKLIN WRIGHT
2. Date of Death Month/Day/Year: 8/15/99
3. Time of Death: 12-30PM
4a. Facility Name (If not institution, give street and number): Johnston Knoll Nursing Home
4b. City, Town, or Location of Death: Balto. Md
4c. County of Death: N. A

Funeral Director

5. Social Security Number: 216 34 5826
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 61 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 3/5/38
9. Birthplace (State or Foreign Country): Md

Usual Residence of Decedent

10a. State: Md
10b. County: N A
10c. City, Town or Location: Balto
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 708 E. 21st
10f. Zip Code: 21218
10g. Citizen of What Country? U. S. A

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 th Grad | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laterer
16b. Kind of Business/Industry: Lock Insulator

17. Father's Name (First, Middle, Last): Walter Wright
18. Mother's Name (First, Middle, Maiden Surname): Lucille Palmer

19a. Informant's Name/Relationship (Type, Print): Theresa Shannon
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 708 E. 21ST Balto. Md. 21218

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Druid Ridge Cem
Date: 8/19/99
20c. Location - City or Town, State: Balto - Md

21. Signature of Funeral Service Licensee: Joseph G. Lockard
22. Name and Address of Facility: Joseph G. Lockard 3/H 1304 N. Central Ave

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Renal Cell Cancer — Year

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Wagat Ali
29c. License number: D47405
29d. Date signed (Month, Day, Year): 8/16/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): HADAT ALI 821 N-Eutaw Street Baltimore MD 21201

State Registrar

31. Date filed (Month, Day, Year): AUG 17 1999
32. Registrar's Signature: D. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25731

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HERMAN WILLIAMS SR

2. Date of Death: Month AUGUST Day 13 Year 1999

3. Time of Death: 5:06 PM

4a. Facility Name (If not institution, give street and number): SINAI HOSPITAL OF BALTIMORE

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: n/a

Funeral Director

5. Social Security Number: 063-03-8955

6. Sex: XX 1 M 2 F

7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 9, 1911

9. Birthplace (State or Foreign Country): Florida

Usual Residence of Decedent

10a. State: Md.

10b. County: n/a

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 XX Yes 2 No

10e. Street and Number: 3912 Dorchester Road

10f. Zip Code: 21215

10g. Citizen of What Country? USA

11. Marital Status: 1 Never Married 2 Married 3 XX Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XX No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 XX No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10th Grade; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Supervisor-Coke Ovens

16b. Kind of Business/Industry: Bethlehem Steel

17. Father's Name (First, Middle, Last): Robert Williams

18. Mother's Name (First, Middle, Maiden Surname): unknown Jessie

19a. Informant's Name/Relationship (Type, Print): Daughter Dr. Gwendolyn Bullock-Smith

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 405 Nottingham Road Baltimore, Md. 21229

20a. Method of Disposition: 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): Arbutus Memorial Park

Date: Aug. 17

20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: Ernest R. Eng Jr

22. Name and Address of Facility: Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. RESPIRATORY FAILURE

Due to (or as a consequence of):

b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. ASBESTOSIS

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS TYPE 2

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 ☑ Yes 2 No

26. Place of Death (Check only one): Hospital: 1 Inpatient 2 ☑ ER/Outpatient 3 DOA; Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death: 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D0053495

29d. Data signed (Month, Day, Year): AUGUST 14 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RYAN M. KRAMER MD

State Registrar

31. Data filed (Month, Day, Year): AUG 17 1999

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

94 10

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25732

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Harry D. Wood

2. Date of Death: Month Aug. Day 16, Year 1999

3. Time of Death: 1:45 am

4a. Facility Name (If not institution, give street and number): Montgomery General Hospital

4b. City, Town, or Location of Death: Olney Maryland

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 160-24-7783

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 1, 1914

9. Birthplace (State or Foreign Country): PA

Usual Residence of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Silver Spring Maryland

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 3700 International Drive

10f. Zip Code: 20906

10g. Citizen of What Country? United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 0

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Salesman

16b. Kind of Business/Industry: Metal

17. Father's Name (First, Middle, Last): Harry Wood

18. Mother's Name (First, Middle, Maiden Surname): Marjorie Dickinson

19a. Informant's Name/Relationship (Type, Print): Ann Wood / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3700 International Drive, Silver Spring MD 20906

20e. Method of Disposition: 1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Saint Dominics Cemetery | Date: August 20, 1999

20c. Location - City or Town, State: Philadelphia, PA

21. Signature of Funeral Service Licensee: Victor P. Doda, Jr.

22. Name and Address of Facility: Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore MD 21230

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death)
a. SEPTIC SHOCK — DAYS

Due to (or as a consequence of):
b. URINARY TRACT INFECTION — DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

RENAL FAILURE

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D38457

29d. Date signed (Month, Day, Year): AUGUST 16, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): A. COSTAS MD 1811 PHILIP DR OLNEY MD 20832

State Registrar

31. Date filed (Month, Day, Year): AUG 17 1999

32. Registrar's Signature: L. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25733

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY WEST

2. Data of Death Month Day Yaar: AUGUST 15 1999

3. Tima of Death: 9:35 AM

4a. Facility Nama (If not institution, giva street and number): MARINER HEALTH OF NORTH ARUNDEL

4b. City, Town, or Location of Daath: GLEN BURNIE

4c. County of Death: ANNE ARUNDEL CO.

Funeral Director

5. Social Sacurity Numbar: 218-26-0827

6. Sax: 1☐ M 2☒ F

7. Aga (In yrs. last birthday): 67 Yrs.

If Undar 1 Yaar: Months / Days

If Undar 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Yaar): April 19 1932

9. Birthplaca (State or Foraign Country): Maryland

Usual Rasidanca of Dacadant

10a. Stata: Md.

10b. County: n/a

10c. City, Town or Location: Baltimore

10d. Insida City Limits: 1☒ Yas 2☐ No

10e. Straat and Numbar: 1621 Jackson Street

10f. Zip Coda: 21230

10g. Citizan of What Country?: USA

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowad 4☐ Divorced

12. Was Dacedant Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No Specify:

14. Raca - American Indian, Black, Whita, atc. Specify: white

15. Decedant's Education (Spacify only highast grada complatad): Elamentary/Secondary (0-12): 12; Collega (1-4or 5+): 0

16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired): Clerical

16b. Kind of Businass/Industry: State Government

17. Fathar's Nama (First, Middla, Last): Harry Robinson

18. Mothar's Nama (First, Middla, Maidan Surnama): Wilda Smith

19a. Informant's Name/Ralationship (Type, Print): Audrey West (Daughter-in-law)

19b. Mailing Address (Street and Number or Rural Routa Numbar, City or Town, State, Zip Code): 8559 Ship Jack Place, Pasadena, Md. 21122

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)

20b. Place of Disposition (Nama of camatary, cramatory or othar placa): Cedar Hill Cemetery

Data: 8/18/99

20c. Location - City or Town, Stata: Brooklyn Park, Md.

21. Signatura of Funaral Sarvica Licansaa: David A. Hayes

22. Nama and Addrass of Facility: McCully-Polyniak Funeral Home P.A. 130 E. Fort Ave., Baltimore, Md. 21230

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that caused the daath. Do not antar tha moda of dying, such as cardiac or respiratory arrast, shock, or haart failure. List only ona cause on each line.

Approximata Intarval Batwaen Onsat and Death

Immediata Causa (Final disaasa or condition rasulting in daath) a. Sepsis — 1 week

Dua to (or as a consequanca of):

Sequantially list condilions, if any, laading to immadiata causa. Entar Underlying Cause (Disaasa or injury that initiatad avants rasulting in daath) Last

b.

Dua to (or as a consequance of):

c.

Dua to (or as a consequance of):

d.

Part II. **Othar significant conditions** contributing to daath but not rasulting in the underlying causa given in Part I.: Renal failure, Paraplegia

23b. Did tobscco use contribute to the causas of death? 1☐ Yas 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings svailabla prior to complation of causa of daath? 1☐ Yas 2☒ No

25. Was case rafarrad to medical examinar? 1☐ Yas 2☒ No

26. Place of Daath (Chack only ona): Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA; Othar: 4☒ Nursing Homa 5☐ Rasidance 6☐ Other (Specify)

27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be datarminad

28a. Data of Injury (Month, Day Yaar)

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describa how injury occurrad

28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Routa Numbar, City or Town, Stata)

29a. Cartifiar (Check only one): 1☒ **Cartifying Physician:** To tha best of my knowladga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of examinetion and/or invastigetion, in my opinion, death occurrad at the time, dete and piece, and dua to tha csuse(s) and manner steted.

29b. Signature and title of cartifiar: MD

29c. Licansa number: D38958

29d. Data signad (Month, Day, Yaar): 8/16/99

30. Nama and addrass of parson who completed causa of daath (Item 23a) (Type, Print): Daljeet Singh Sidhu 1413 Annapolis Road #106 odenton MD21113

State Registrar

31. Data filad (Month, Day, Yaar): AUG 17 1999

32. Ragistrar's Signatura: Geneva G. Sparks

DHMH 16 Rsv 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that tha daath certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attanding physician and completely filled in by the funeral director, page 2 should be detached for usa as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25734

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Madeline Whiteford
2. Date of Death (Month, Day, Year): August 12, 1999
3. Time of Death: 5:50 p.m.
4a. Facility Name (If not institution, give street and number): Good Samaritan Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-22-5553
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 27, 1915
9. Birthplace (State or Foreign Country): West Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1217 Cedarcroft Road
10f. Zip Code: 21239
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th Grade | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Jacob Scheerer
18. Mother's Name (First, Middle, Maiden Surname): Florence Purdam

19a. Informant's Name/Relationship (Type, Print): Joyce Krout (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1540 Fountain Glen Dr., Bel Air, MD 21015

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gardens of Faith | Date: 8/16/99
20c. Location - City or Town, State: Baltimore

21. Signature of Funeral Service Licensee: Brian D Fuss
22. Name and Address of Facility: Schimunek Funeral Home, Inc. 9705 Belair Road, Baltimore, MD 21236

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. INTRA CEREBRAL HEMMORHAGE.
Due to (or as a consequence of):
b. HYPERTENSION.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD
29c. License number: P11390
29d. Date signed (Month, Day, Year): August 14, 99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Mona Sabra, 5601 Loch Raven Blvd., Baltimore, MD 21239

State Registrar

31. Date filed (Month, Day, Year): AUG 17 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25735

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Charles Edward Wrightson
2. Date of Death Month Day Year: August 15 1999
3. Time of Death: 12:26 AM
4a. Facility Name *(If not institution, give street and number)*: Union Memorial Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-12-8243
6. Sex: 1 X M 2 ☐ F
7. Age *(In yrs. last birthday)*: 76 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Dec. 29, 1922
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 X Yes 2 ☐ No
10e. Street and Number: 3440 Woodstock Avenue
10f. Zip Code: 21213
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 yrs. / College (1-4or 5+)
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Construction Project Manager
16b. Kind of Business/Industry: Baltimore City

17. Father's Name *(First, Middle, Last)*: William S. Wrightson
18. Mother's Name *(First, Middle, Maiden Surname)*: Beulah Shores

19a. Informant's Name/Relationship *(Type, Print)*: Mrs. Barbara Hill / Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4806 Crosswood Ave. Baltimore, Md. 21214

20a. Method of Disposition: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gardens of Faith Cem.
Date: 8/19/99
20c. Location - City or Town, State: Overlea, Maryland

21. Signature of Funeral Service Licensee: Carl J. Lange
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Md. 21204

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Exsanguination — Approximate Interval Between Onset and Death: 2 hours

Due to (or as a consequence of): b. Mediastinitis — 2 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 X No

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No

26. Place of Death *(Check only one)*: Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other *(Specify)*

27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 X **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner es stated. 2 ☐ **Medical Examiner**: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and pieca, and due to the cause(s) and menner steted.

29b. Signature and title of certifier: Lawrence R. Ferber M.D.
29c. License number: AT2438946
29d. Date signed *(Month, Day, Year)*: August 15, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Lawrence R. Ferber M.D. 201 East University Parkway Baltimore, Md. 21202

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 17 1999
32. Registrar's Signeture: Jimmie G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Charles E. Wrightson

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25736

Walter Ambrose Ward
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner — To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last): Walter Ambrose Ward			2. Date of Death (Month, Day, Year): August 12, 1999	3. Time of Death: 4:15 P.M.
4a. Facility Name (If not institution, give street and number): Oak Crest Village Care Center	4b. City, Town, or Location of Death: Parkville	4c. County of Death: Baltimore County		

Funeral Director

5. Social Security Number: 200-09-6265	6. Sex: 1☒ M 2☐ F	7. Age (In yrs. last birthday): 86 Yrs.	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year): Sept 1, 1912	9. Birthplace (State or Foreign Country): Pennsylvania	

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore County	Parkville	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
8820 Walther Boulevard	21234	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	4 yrs	Clerk	Baltimore County

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
James Ward	Loretta Osbourne

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Marie C. Ward (Wife)	8820 Walther Boulevard #2014, Parkville, MD 21234

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Mt Maria Cemetery	8/16/99	Towson, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Martin D. Lawson Martin D. Lawson	Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road, Baltimore, Maryland 21212

Physician /Medical Examiner — Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Advanced dementia	yrs.
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Multiple cerebrovascular accidents

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Kendall Faulkner	D25643	08/13/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
H.K. Faulkner MD / 8600 Walther Blvd / Baltimore MD 21234

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
AUG 17 1999	▶ Irene B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25737

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Andre' Woods

2. Date of Death Month Day Year: AUG 16, 1999

3. Time of Death: 2:08 AM

4e. Facility Name *(If not institution, give street and number)*: 1009 Hallimont Road

4b. City, Town, or Location of Death: Catonsville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 267-40-8089

6. Sex: 1☐M 2☐F — X

7. Age *(In yrs. last birthday)*: 76 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: AUG 27, 1922

9. Birthplace *(State or Foreign Country)*: Florida

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 1009 Hallimont Road

10f. Zip Code: 21228

10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☐No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐Yes 2☒No *Specify:*

14. Raca - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) | College (1-4or 5+): 5+

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Administrative

16b. Kind of Business/Industry: Social Security Administration

17. Father's Name *(First, Middle, Last)*: George Woods

18. Mother's Name *(First, Middle, Meiden Surname)*: Raymonde Thiebaux

19a. Informant's Name/Relationship *(Type, Print)*: Gladys C. Woods/wife

19b. Malling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 1009 Hallimont Rd. Catonsville, MD 21228

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other piece)*: Barnes Cemetery

Date: 08/20/99

20c. Location - City or Town, State: Ocala, Florida

21. Signature of Funeral Service Licensee: Edward A. Gregorchik

22. Name and Address of Facility: MacNabb Funeral Home, P.A. 301 Frederick Rd. Baltimore, MD 21228

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, complications that caused tha death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. Use only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Finel diseasa or condition resulting in death)

a. Melanoma brain metastases

Due to (or es a consequenca of):

b. Malignant Melanoma — 6 mos

Sequentially list conditions, if any, leading to Immediete causa. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last

Due to (or as e consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uee contribute to the cause of death? 1☐Yee 2☒No 3☐Probably 4☐Unknown

24a. Was en eutopsy performed? 1☐Yes 2☒No

24b. Were eutopsy findings availabia prior to completion of causa of deeth? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Naturel 2☐Accident 3☐Suicida 4☐Homicida 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Dascribe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒**Certifying Phyeician:** To the best of my knowledge, death occurred at the time, dete end place, end due to the cause(s) and manner es stated. 2☐**Medicaf Exeminer:** On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the ceuse(s) and menner stated.

29b. Signeture and title of certifier: RW Wilson MD

29c. License number: D41476

29d. Date signed *(Month, Day, Year)*: 08/16/1999

30. Name end address of person who completed cause of death (Item 23a) (Type, Print): RAYMOND W. WILSON MD 6565 N. Charles St., Suite 416, Baltimore, MD 21204-5803

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requiras that the death certificata be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be datached for use es the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 17 1999

32. Registrar Signature: L. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25738

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARQUERITE Wilkins

2. Date of Death Month, Day, Year: Aug. 11, 1999

3. Time of Death: 6:44pm

4a. Facility Name (If not institution, give street and number): Good Samaritan Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-16-7832

6. Sex: 1☐ M 2☑ F

7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): Dec. 10, 1916

9. Birthplace (State or Foreign Country): MARYland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☑ Yes 2☐ No

10e. Street and Number: 2401 College Avenue

10f. Zip Code: 21214

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 5+ | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Baltimore Educator

16b. Kind of Business/Industry: Balto City Schools

17. Father's Name (First, Middle, Last): Joseph R. WATERS

18. Mother's Name (First, Middle, Maiden Surname): Lillian Banks

19a. Informant's Name/Relationship (Type, Print): Edward W. Wilkins JR

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2401 College Ave Balto Md 21214

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☑ Other (Specify): Entombment

20b. Place of Disposition (Name of cemetery, crematory or other place): Arbutus Mem Pk

Date: 8/16

20c. Location - City or Town, State: Arbutus, Md

21. Signature of Funeral Service Licensee: Gloria Adams Jones

22. Name and Address of Facility: Marshall W. Jones, Jr. F.H. PA 401 Edmondson Ave. Balto Md 21229

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Aspiration Pneumonia — 1 hour

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

demented

Normal Pressure Hydrocephalus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☑ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: C Sperling

29c. License number: D28987

29d. Date signed (Month, Day, Year): 8/12/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CARL SPERLING, M.D. 5601 LOCH RAVEN BLVD BALTO. MD 21239

State Registrar

31. Date filed (Month, Day, Year): AUG 17 1999

32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

A4 15

99-4712-003
jhm
MICHELLO PAYGE
YOSUICO AMEND ITEMS: #1, 23 PART I, 27, 28A-F PER MEO G774 8-19-99 WR

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25739

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Michelle Paige Yosuico
2. Date of Death (Month, Day, Year): AUGUST 14, 1999
3. Time of Death: 22:45 PM
4a. Facility Name (If not institution, give street and number): 11 McGUIRK
4b. City, Town, or Location of Death: GLEN BURNIE
4c. County of Death: ANNE ARUNDAL

Funeral Director

5. Social Security Number: 212-68-8392
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 47 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 20, 1952
9. Birthplace (State or Foreign Country): Baltimore, Md.

Usual Residence of Decedent

10a. State: Md.
10b. County: Anne Arundal
10c. City, Town or Location: Glen Burnie
10d. Insida City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 11 McGuirk Ave.
10f. Zip Code: 21060
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yas, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 1☐ Yas 2☒ No Specify:
14. Race - American Indian, Black, White, atc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): +2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Registered Nurse
16b. Kind of Businass/Industry: Medical

17. Father's Nema (First, Middle, Last): George H. Murray
18. Mother's Nama (First, Middle, Maiden Surname): Clara M. Green

19a. Informant's Name/Ralationship (Type, Print): Terilynn Murray - sister
19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code): 4219 Vermont Ave. Baltimore, Maryland 21229

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stata 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Nama of cematary, crematory or other place): Evergreen Mem. Gardens Data: Aug. 18, 1999
20c. Location - City or Town, Stata: Finksburg, Md.

21. Signatura of Funaral Service Licensee: Justin R. [illegible]
22. Nama and Addrass of Facility: Eckhardt Funeral Chapel 21117, 11605 Reisterstown Road Owings Mills, Md.

Physician /Medical Examiner

23a. Part I. Enter tha disease, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or raspiratory arrest, shock, or heart failura. List only ona cause on aach line. (Approximata Interval Between Onset and Death)

Immedieta Cause (Final diseasa or condition rasulting in death): a. NARCOTIC INTOXICATION

Dua to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Wara autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was casa refarred to medical examiner? 1☒ Yas 2☐ No

26. Place of Deeth (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Homa 5☒ Residence 6☐ Othar (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide ~~5☐ Pending investigation~~ 5☒ 6☒ Could not be determined

28a. Dete of Injury (Month, Day Year): UNKNOWN
28b. Tima of Injury: UNKNOWN M
28c. Injury at Work? 1☐ Yas 2☒ No
28d. Describe how injury occurred: SUBJECT INGESTED NARCOTIC
28e. Piece of Injury - At homa, farm, street, factory, office building, etc. (Specify): HOME
28f. Location (Street and Number or Rural Route Number, City or Town, Stete): 11 MCGURIK, GLEN BURNIE, ANNE ARUNDEL COUNTY, MD

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the tima, data and place, end due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of axaminetion and/or investigation, in my opinion, deeth occurred at the time, data end place, and due to the cause(s) and mannar stated.

29b. Signatura and title of certifier: [signature]
29c. License number: OCME
29d. Data signed (Month, Day, Year): AUGUST 15, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): [signature] 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filed (Month, Day, Year): AUG 17 1999
32. Registrar's Signatura: Barbara G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25740

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ronald Clyde Albaugh
2. Date of Death (Month, Day, Year): August 1, 1999
3. Time of Death: 1:45 PM
4a. Facility Name (If not institution, give street and number): 7202 Central Avenue
4b. City, Town, or Location of Death: Takoma Park
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 235-34-0658
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 72 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 8, 1926
9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Takoma Park
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 7202 Central Avenue
10f. Zip Code: 20912
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: Unknown
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Episcopal Priest
16b. Kind of Business/Industry: Religious Ministry

17. Father's Name (First, Middle, Last): Jeremiah Robinson Albaugh
18. Mother's Name (First, Middle, Maiden Surname): Lenore Madeline Carroll

19a. Informant's Name/Relationship (Type, Print): Christopher B. Albaugh (son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11619 Drumcastle Terrace, Germantown, MD 20876

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory — Date: 8-3-99
20c. Location - City or Town, State: Beltsville, Maryland

21. Signature of Funeral Service Licensee: ▶ Eileen W. Rapp
22. Name and Address of Facility: Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
e. Coronary Artery Disease — Approximate Interval Between Onset and Death: years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Coronary Atherosclerosis — years

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Insulin Dependent Diabetes Mellitus
Hyperlipidemia

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Samuel Itscoitz MD
29c. License number: D 05568
29d. Date signed (Month, Day, Year): August 2, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Samuel B. Itscoitz, M. D., 10313 Georgia Avenue, #306, Silver Spring, MD 20902

State Registrar

31. Date filed (Month, Day, Year): AUG 03 1999
32. Registrar's Signature: ▶ G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25741

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Bernice Allen
2. Date of Death (Month, Day, Year): July 31, 1999
3. Time of Death: 1 AM.
4a. Facility Name (If not institution, give street and number): Brooke Grove Nursing Home.
4b. City, Town, or Location of Death: Sandy Springs
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 230-05-7608
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug 21,13
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Sandy Springs
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 18430 Brooke Grove Rd.
10f. Zip Code: 20860
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Banker
16b. Kind of Business/Industry: Private

17. Father's Name (First, Middle, Last): John Turner Putnam
18. Mother's Name (First, Middle, Maiden Surname): Mary Clem

19a. Informant's Name/Relationship (Type, Print): Marcia Ritter/Trust Officer
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 17801 Georgia Ave. Olney, MD. 20832

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Union Cemetery
Date: 8/2
20c. Location - City or Town, State: Burtonvilles

21. Signature of Funeral Service Licensee: Michael Bailey
22. Name and Address of Facility: Takoma Funeral Home. 254 Carroll St.NW. Washington, DC. 20012

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. GASTRO INTESTINAL HEMORRHAGE — 12 HOURS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
PROGRESSIVE SENILE DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ted Howe MD
29c. License number: D33700
29d. Date signed (Month, Day, Year): August 2, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): TED HOWE, 7542 OVERLOOK DR, BOONSBORO, MD 21713

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): AUG 03 1999
32. Registrar's Signature: Lenora G. Sparks

DHMH 16 Rev 6/95

99-4513-033
JAD
WILFEDO AMAYA
Unknown 99-169 AMEND#11 PER F.H. G776 10-12-99 J.A.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25742

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: WILFREDO AMAYA
2. Date of Death Month / Day / Year: August 1, 1999
3. Time of Death: 12:11 PM
4a. Facility Name *(If not institution, give street and number)*: Md. Route 210 and Palmer Road
4b. City, Town, or Location of Death: Fort WAshinton
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 228-59-4024
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 23 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 10/11/75
9. Birthplace *(State or Foreign Country)*: El Salvador

Usuel Residence of Decedent

10a. State: Md.
10b. County: Prince Georges
10c. City, Town or Location: Fort Washington
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1733 Rhodesia Avenue
10f. Zip Code: 20744
10g. Citizen of What Country?: El Salvador

11. Marital Status: 1 [X] ~~Never Married~~ 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [X] Yes 2 [ ] No Specify: El Salvadoran
14. Race - American Indian, Black, White, etc. Specify: Hispanic

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 1
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Construction Foreman's Asst.
16b. Kind of Business/Industry: Construction

17. Father's Name *(First, Middle, Last)*: Gregorio Amaya Lemus
18. Mother's Name *(First, Middle, Maiden Surname)*: Maria Rodriguez

19a. Informant's Name/Reletionship *(Type, Print)*: Gregorio Amaya
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1733 Rhodesia Ave. Fort Washington, Md. 20744

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Resurrection — Date: 08/06/99
20c. Location - City or Town, State: Clinton, Md.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: W. H. Bacon Funeral Home, Inc. 3447 14th St., N.W. Washington, D.C. 20010

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

JW

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Multiple injuries
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? [X] Yes 2 [ ] No
26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other *(Specify)*: Scene
27. Manner of Death: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day, Year)*: 8-1-99
28b. Time of Injury: 1210 M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: Motor vehicle accident
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: street
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: Route 210 / Palmer Rd Fort Washington, Maryland

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. [X] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: O.C.M.E.
29d. Date signed *(Month, Day, Year)*: August 2, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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State Registrar

31. Date filed *(Month, Day, Year)*: AUG 04 1999
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND: #23 PART I, PER MD G775 9-8 WR. State of Maryland / Department of Health and Mental Hygiene 99 25743

AMEND ITEMS: #28A-F PER MEO G774 8-25-99 WR. **Certificate of Death** Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BURTON HOWELL ANDREWS
2. Date of Death: Month AUGUST Day 1 Year 1999
3. Time of Death: 2356
4a. Facility Name (If not institution, give street and number): 11713 MILBERN DRIVE
4b. City, Town, or Location of Death: POTOMAC
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 215-38-9401
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 14, 1916
9. Birthplace (State or Foreign Country): California

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Potomac
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 11713 Milbern Drive
10f. Zip Code: 20854
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1934-1973
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Officer
16b. Kind of Business/Industry: U.S. Navy

17. Father's Name (First, Middle, Last): (not available) Andrews
18. Mother's Name (First, Middle, Maiden Surname): Margaret Howell

19a. Informant's Name/Relationship (Type, Print): Eurith M. Andrews/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11713 Milbern Drive, Potomac, Maryland 20854

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Montgomery Crematorium, Inc. Date: Aug. 3, 1999
20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: Robert A. Pumphrey M00198
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. GUNSHOT TO HEAD ~~SELF-INFLICTED GUNSHOT WOUND TO HEAD~~

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DEPRESSION

EMOTIONAL

23b. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☒ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year): AUGUST 1, 1999
28b. Time of Injury: 2356 M
28c. Injury at Work? 1 ☐ Yes 2 ☒ No
28d. Describe how injury occurred: SELF-INFLICTED GUNSHOT WOUND TO HEAD
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): HOME
28f. Location (Street and Number or Rural Route Number, City or Town, State): 11713 MILBERN DR. POTOMAC

29a. Certifier (Check only one): 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M.D. (OME)
29c. License number: 015236
29d. Date signed (Month, Day, Year): AUGUST 2, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CARL MARGOLIS, M.D. 11125 ROCKVILLE PIKE, ROCKVILLE, MD 20852

State Registrar

31. Date filed (Month, Day, Year): AUG 03 1999
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25744

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lee R. April
2. Date of Death (Month, Day, Year): July 29, 1999
3. Time of Death: 6:22 AM
4a. Facility Name (If not institution, give street and number): Suburban Hospital
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-62-1102
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 92 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 11, 1907
9. Birthplace (State or Foreign Country): Washington DC

Usual Residence of Decedent

10a. State: D.C.
10b. County: N/A
10c. City, Town or Location: Washington
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 2822 27th St N.W.
10f. Zip Code: 20008
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Abraham Kaminsky
18. Mother's Name (First, Middle, Maiden Surname): Helen Goldberg

19a. Informant's Name/Relationship (Type, Print): Hugh April/ Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12000 Apple Knoll Ct., N. Potomac, MD 20878

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Adas Israel Cemetery | Date: Aug. 1 1999
20c. Location - City or Town, State: Washington, DC

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike, Rockville, MD 29852

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Thoracic Empyema — weeks
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Harris M Kenner MD
29c. License number: D06019
29d. Date signed (Month, Day, Year): July 29, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): HARRIS M KENNER, M.D. 5454 Wisconsin Avenue Chevy Chase MD 20815

State Registrar

31. Date filed (Month, Day, Year): AUG 03 1999
32. Registrar's Signature: Geneva G. Sparks

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Lee April July 29, 1999 0622

12

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25745

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: OLGA ARANOVICH

2. Date of Death: Month JULY Day 31 Year 1999

3. Time of Death: 1.25 AM

4a Facility Name *(If not institution, give street and number)*: HEBREW HOME OF GREATER WASHINGTON

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 218-37-5175

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 96 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: MARCH 3, 1903

9. Birthplace *(State or Foreign Country)*: POLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: MONTGOMERY

10c. City, Town or Location: ROCKVILLE

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 6121 MONTROSE ROAD

10f. Zip Code: 20852

10g. Citizen of What Country?: RUSSIA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yes, Giva Yaar or Dates: X

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, atc. Specify: WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOMEMAKER

16b. Kind of Business/Industry: OWN HOME

17. Father's Name *(First, Middle, Last)*: ABRAHAM SPECTOR

18. Mother's Name *(First, Middle, Maiden Surnama)*: UNKNOWN

19a. Informant's Name/Relationship *(Type, Print)*: MICHAEL HOCHSTEIN (GRANDSON)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4207 CEDAR TREE LANE-BURTONSVILLE, MD. 20866

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Nama of cemetery, crematory or other place)*: CHESED SHEL EMMES CEM.

Date: 8/3/99

20c. Location - City or Town, State: WASHINGTON, D.C.

21. Signature of Funeral Service Licensee: Emanuel Danzansky

22. Name and Address of Facility: DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. ~~1170 ROCKVILLE PIKE~~-ROCKVILLE, MD. 20852

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disaase or condition resulting in death) a. UPPER GASTRO INTESTINAL BLEED — 2 WEEKS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequenca of):

c.

Due to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ ~~No~~ 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ ~~No~~

24b. Were autopsy findings available prior to compiation of cause of death? 1☐ Yas 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ ~~No~~

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ ~~Nursing Home~~ 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ ~~Natural~~ 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ ~~Certifying Physician~~: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: P. Talwar, M.D.

29c. License number: D36552

29d. Date signed *(Month, Day, Year)*: JULY 31 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): P. TALWAR, 6121 Montrose Rd. Rockville MD. 20852

State Registrar

31. Data filad *(Month, Day, Year)*: AUG 04 1999

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

2

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEM AMENDED ITEM #7 PER FH G774 8/26/99 AH

Certificate of Death

Reg. No. 99 25746

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Nazira S. Ayoroa
2. Date of Death (Month, Day, Year): August 3, 1999
3. Time of Death: 01:37
4e. Facility Name (If not institution, give street and number): SHADY GROVE ADVENTIST HOSPITAL
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 577-80-7381
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): ~~82~~ 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 16, 1914
9. Birthplace (State or Foreign Country): Bolivia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Potomac
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 11044 Powder Horn Drive
10f. Zip Code: 20854
10g. Citizen of What Country?: United States

11. Meritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☒ Yes 2☐ No Specify: Bolivian
14. Reca - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Miguel Simon
18. Mother's Name (First, Middle, Maiden Surname): Elisa Roca

19a. Informant's Name/Relationship (Type, Print): Nazira Simon/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11044 Powder Horn Drive, Potomac, Maryland 20854

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Montgomery Crematorium, Inc. | Date: Aug. 4, 1999
20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: David E. Perry. M00803
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. acute pulmonary edema
Due to (or as a consequence of):
b. Ischemic Heart Disease
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. acute respiratory failure.
Due to (or as a consequence of):
d. Hypertension.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hypothyroidism.
anoxic Encephalopathy.
Seizures.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how Injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and menner steted.
29b. Signature and title of certifier: Vinu Gupta
29c. License number: D41162
29d. Date signed (Month, Day, Year): August 3 1999
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): V. Gupta 19529, Doctors Drive G'town MD 20876

State Registrar

31. Date filed (Month, Day, Year): AUG 05 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25747

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARTIN JOSEPH ABBOTT

2. Date of Death: Month August Day 1 Year 1999

3. Time of Death: 2030

4a. Facility Name *(If not institution, give street and number)*: PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 213-34-5566

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 62 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: March 12, 1937

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Somerset

10c. City, Town or Location: Eden

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 14556 Sandy Lane

10f. Zip Code: 21822

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 College (1-4or 5+): –

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Facility Clerk

16b. Kind of Business/Industry: Perdue Farms

17. Father's Name *(First, Middle, Last)*: William Joseph Abbott

18. Mother's Name *(First, Middle, Maiden Surname)*: Anna Baranoski

19a. Informant's Name/Relationship *(Type, Print)*: Rita M. Abbott/Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 14556 Sandy Lane, Eden, MD 21822

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Springhill Memory Gardens

Date: 8/4/99

20c. Location - City or Town, State: Hebron, MD

21. Signature of Funeral Service Licensee: David A. Bompasso M01051

22. Name and Address of Facility: Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. acute myocardial infarction — 1 hr

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Status post low anterior resection — 6 days

Due to (or as a consequence of):

c. history of rectal cancer

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Janet Wasson

29c. License number: 44979

29d. Date signed *(Month, Day, Year)*: 8/3/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JANET WASSON, M.D. 145 E. CARROLL ST. SALISBURY, MD

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 03 1999

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

213-34-5566 MARTH ABBOTT

to record

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25748

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ALEXANDER J. ANDERSON, JR.

2. Date of Death — Month: AUGUST Day: 4 Year: 1999

3. Time of Death: 5:25AM

4a. Facility Name *(If not institution, give street and number)*: SACRED HEART HOSPITAL

4b. City, Town, or Location of Death: CUMBERLAND

4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 219 14 5952

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 74 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: NOV 16 1924

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ALLEGANY

10c. City, Town or Location: FROSTBURG

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 13412 UPPER GEORGES CREEK ROAD, SW

10f. Zip Code: 21532

10g. Citizen of What Country?: U.S.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)* — Elementary/Secondary (0-12): 10 — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: PAPER FINISHER

16b. Kind of Business/Industry: PAPER MILL

17. Father's Name *(First, Middle, Last)*: ALEXANDER ANDERSON, SR.

18. Mother's Name *(First, Middle, Maiden Surname)*: ANNIE BROADWATER

19a. Informant's Name/Relationship *(Type, Print)*: ELAINE ANDERSON / WIFE

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)* 21532: 13412 UPPER GEORGES CREEK ROAD, SW, FROSTBURG, MD

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: LAUREL HILL CEMETERY — Date: 8/6/99

20c. Location - City or Town, State: BARTON, MD

21. Signature of Funeral Service Licensee: Eric W. Sowers

22. Name and Address of Facility: SOWERS FUNERAL HOME, P.A. 60 W. MAIN ST. FROSTBURG, MD 21532

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. pneumonia — 3 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Right Thalamic Infarct. Left Hemiplegia
CORONARY ARTERY Disease, Status post. CORONARY by pass
CHRONIC ATRIAL Fibrillation

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: S. Changsud

29c. License number: D25638

29d. Data signed *(Month, Day, Year)*: AUGUST 4, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SATURNINA CHANG, M.D. 10701 New Georges Creek S.W. Suite 3. Frostburg Maryland 21532

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 06 1999

32. Registrar's Signature

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

99 25749

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ALMA F. BONNER			2. DATE OF DEATH (Month, Day, Year): 07.31.1999	3. TIME OF DEATH: 10:00 AM
4. SOCIAL SECURITY NUMBER: 309.32.1027	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 89 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 10.14.1909	8. BIRTHPLACE (State or Foreign Country): Illinois
9a. FACILITY NAME (If not institution, give street and number): COLLINGWOOD NURSING HOME		9b. CITY, TOWN OR LOCATION OF DEATH: ROCKVILLE		9c. COUNTY OF DEATH: MONTGOMERY

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
MD	MONTGOMERY	ROCKVILLE	1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
299 HURLEY AVENUE	20850	USA

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☒ NO Specify:	Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
12		BUTCHER	MARKET

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
FREDERICK SCHEVRER	ANNA DeTALLEUR

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
BARBARA NOTTINGHAM/DAUGHTER	13 DALE DRIVE, ROCKVILLE, MARYLAND 20850

20a. METHOD OF DISPOSITION	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, other place)	DATE	20c. LOCATION — City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	CALVARY CEMETERY	8.5.99	INDIANAPOLIS, INDIANA

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ [signature]	EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MD 20852

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiec or respiratory srrest, shock, or heert feilure. List only one ceuse on eech line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Finel disease or condition resulting in death) →	a. Congestive heart failure	1 Day
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentielly list conditions, if eny, leading to immediete ceuse. Enter UNDERLYING CAUSE (Diseese or injury that initiated events resulting in death) LAST	b. Hypertensive arteriosclerotic cerebrovascular disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I.

Coronary artery disease. Dementia. Anemia of chronic disease. Esophagitis. Peripheal neuropathy

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☒ NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
H. Robert Birschbach MD	04115	▶ July 31, 1999

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
DR. ROBERT H. BIRSCHBACH, 6320 DEMOCRACY BLVD., BETHESDA, MD 20817

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 06 1999	Geneva G. Sparks

DHMH-16 Rev 1/89

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25750

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Viola E. Babits

2. Date of Death Month Day Year: August 3, 1999

3. Time of Death: 8:55pm

4a. Facility Name *(If not institution, give street and number)*: SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 143-05-3080

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jan. 24, 1918

9. Birthplace *(State or Foreign Country)*: New Jersey

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Gaithersburg

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 403 Christopher Avenue #31

10f. Zip Code: 20879

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Joseph E. Babits

18. Mother's Name *(First, Middle, Maiden Surname)*: Angela Gryzbek

19a. Informant's Name/Relationship *(Type, Print)*: Valerie Trabue (Daughter)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)* 18609 Walkers Choice Road #3, Montgomery Village, MD 20886

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gate of Heaven Cemetery

Date: 8/6/99

20c. Location - City or Town, State: Silver Spring, Maryland

21. Signature of Funeral Service Licensee: ▶ Curtis E. Day

22. Name and Address of Facility: DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. MYOCARDIAL INFARCTION — 24HR.

Due to (or as a consequence of):
b. Ischemic Heart Disease — 6YR.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Aspiration pneumonia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Frank J. Mayo, MD

29c. License number: 023630

29d. Date signed *(Month, Day, Year)*: August 4, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Frank J. Mayo, MD 16220 Frederick Rd #213, Gaithersburg, Maryland 20877

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 05 1999

32. Registrar's Signature: ▶ Irene G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25751

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOHN W. BAXTER
2. Date of Death: Month AUGUST Day 5 Year 1999
3. Time of Death: 0814
4e. Facility Name (If not institution, give street and number): SUBURBAN HOSPITAL
4b. City, Town, or Location of Death: BETHESDA
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 578-46-9735
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 4, 1913
9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1377 Canterbury Way
10f. Zip Code: 20854
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Owner
16b. Kind of Business/Industry: Boat House

17. Father's Name (First, Middle, Last): Francis Baxter
18. Mother's Name (First, Middle, Maiden Surname): Mary Klug

19a. Informant's Name/Relationship (Type, Print): Norma Lee Baxter (wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as 10

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory
Date: 8-6-99
20c. Location - City or Town, State: Beltsville, Maryland

21. Signature of Funeral Service Licensee: ▶ Eileen W. Rapp
22. Name and Address of Facility: Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: LACERATION OF SCALP

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year): AUGUST 1, 1999
28b. Time of Injury: N 1300 M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: FELL DOWN SEVERAL STEPS
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): HOME
28f. Location (Street and Number or Rural Route Number, City or Town, State): 1377 CANTERBURY WAY ROCKVILLE, MD

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ (OME)
29c. License number: D15236
29d. Date signed (Month, Day, Year): AUGUST 5, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CARL I MARGOLIS, MD. 11125 ROCKVILLE PIKE, ROCKVILLE, MD 20852

State Registrar

31. Date filed (Month, Day, Year): AUG 06 1999
32. Registrar's Signature: ▶ Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

(5) (6)

John Baxter 8/5/99 08:14am

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25752

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Charlotte P. Berger
2. Date of Death (Month, Day, Year): July 28, 1999
3. Time of Death: 5:00pm
4a. Facility Name (If not institution, give street and number): 15310 Pine Orchard Dr. #C-2
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-05-7479
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 18, 1915
9. Birthplace (State or Foreign Country): Egypt

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 15310 Pine Orchard Dr. #C-2
10f. Zip Code: 20906
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary
16b. Kind of Business/Industry: Federal Government

17. Father's Name (First, Middle, Last): Israel Pomerantz
18. Mother's Name (First, Middle, Maiden Surname): Sarah Gordon

19a. Informant's Name/Relationship (Type, Print): Dr. S. Nathan Berger/Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 800 4th St. SW Washington DC 20024

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan | Date: 7/30/99
20c. Location - City or Town, State: Alexandria VA

21. Signature of Funeral Service Licensee: Michael Beidler
22. Name and Address of Facility: Takoma Funeral Home 254 Carroll St NW Washington DC 20012

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. Lung Cancer
Due to (or as a consequence of):
b. Chronic obstructive lung Disease
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Coronary Artery Disease
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M. Maryuma MD Family Practice Physician
29c. License number: MD D50809
29d. Date signed (Month, Day, Year): 7/29/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 6111 Executive Blvd Rockville, MD 20852

State Registrar

31. Date filed (Month, Day, Year): AUG 02 1999
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

ORIGINAL

Please Type or Print in Black indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25753

Amend #7,8/3/99,BMW,Montg.Co.

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: KAREN MARIE BLAIR
2. Data of Death Month Day Year: 07.29.1999
3. Time of Death: 3:15 AM
4a. Facility Name *(If not institution, give street and number)*: 37 LLOYD MINSTER COURT
4b. City, Town, or Location of Death: NORTH POTOMAC
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 087.36.3975
6. Sex: 1☐ M 2☐ F
7. Age *(In yrs. last birthday)*: ~~57~~ 56 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: 11.12.1942
9. Birthplaca *(Stata or Foreign Country)*: NY

Usual Rasidence of Decedent

10a. Stata: MARYLAND
10b. County: MONTGOMERY
10c. City, Town or Location: NORTH POTOMAC
10d. Insida City Limits: 1☐ Yas 2☒ No
10a. Street and Number: 37 LLOYD MINSTER COURT
10f. Zip Code: 20878
10g. Citizan of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yas, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indien, Black, Whita, atc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grada completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT use retired)*: ADMINISTRATIVE ASSISTANT
16b. Kind of Businass/Industry: CONFERENCE PLANNING

17. Father's Nama *(First, Middle, Last)*: CARLTON H. KRAUSE
18. Mother's Name *(First, Middle, Maiden Surnama)*: HELEN JOHNSON

19a. Informant's Name/Ralationship *(Type, Print)*: KATHERINE SULLIVAN/DAUGHTER
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stata, Zip Code)*: 37 LLOYD MINSTER CT, NORTH POTOMAC, MD 20878

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☒ Removal from Stata 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Nama of cemetary, cremetory or other place)*: FERNCLIFF CREMATORY
Data: 8.8.99
20c. Location - City or Town, Stete: HARTSDALE, NEW YORK

21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MD 20852

Physician /Medical Examiner

23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on aach line.

Approximata Intarval Between Onset end Deeth

Immediata Causa (Final disease or condition resulting in death): a. BLADDER CANCER — 4 MONTHS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was en eutopsy performed? 1☐ Yas 2☒ No

24b. Were eutopsy findings aveilable prior to complation ot causa of deeth? 1☐ Yes 2☐ No

25. Was cesa refarred to medical examiner? 1☐ Yas 2☒ No

26. Place of Deeth *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Homa 5☒ Rasidanca 6☐ Othar *(Specify)*

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Year)*
28b. Tima of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At homa, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Routa Number, City or Town, Steta)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at tha tima, data and placa, end due to tha causa(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D29675
29d. Date signed *(Month, Day, Year)*: July 29, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert Bollard MD 9707 Medical Center Dr Rockville, MD

State Registrar

31. Data filed *(Month, Day, Year)*: AUG 03 1999
32. Registrar's Signatura: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25754

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: DAVID H. BOOTHE
2. Date of Death Month / Day / Year: August 1, 1999
3. Time of Death: 5:50pm
4a. Facility Name *(If not institution, give street and number)*: SHADY GROVE ADVENTIST HOSPITAL
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 579-52-6393
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 87 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: June 13, 1912
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Potomac
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 10432 Democracy Lane
10f. Zip Code: 20854
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Superintendent
16b. Kind of Business/Industry: Dairy

17. Father's Name *(First, Middle, Last)*: Joseph Boothe
18. Mother's Name *(First, Middle, Maiden Surname)*: Elizabeth Cecilia Hamett

19a. Informant's Name/Relationship *(Type, Print)*: David L. Boothe/ Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 10432 Democracy Lane , Potomac, MD 20854

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gate of Heaven Cemetery — Date: Aug 5 1999
20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: Steven D Strad
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Silver Spring, MD

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	cerebrovascular accident	3days
Due to (or as a consequence of): b.	hypotension	3days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	urosepsis	3days
Due to (or as a consequence of): d.	previous stroke	8months

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: hypertension

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature end title of certifier: Alan Pollack MD
29c. License number: D33443
29d. Date signed *(Month, Day, Year)*: August 2, 1999

30. Name end address of person who completed cause of death (Item 23e) (Type, Print): Alan R. Pollack, M.D. 809 V. US Mill Rd Rockville Md 20851

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 03 1999
32. Registrar's Signature: Geneva G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25755

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WILLIAM L. BOWERS, JR.

2. Date of Death (Month, Day, Year): AUG 2, 1999

3. Time of Death: 1:35 AM

4a. Facility Name (If not institution, give street and number): WASHINGTON ADVENTIST HOSPITAL

4b. City, Town, or Location of Death: TAKOMA PARK

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 578-10-4226

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 85 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JULY 17, 1914

9. Birthplace (State or Foreign Country): VIRGINIA

Usual Residence of Decedant

10e. State: MD.

10b. County: PRINCE GEORGES

10c. City, Town or Location: W. HYATTSVILLE

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 6119 SARGENT RD.

10f. Zip Code: 20782

10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Evar In U.S. Armed Forcas? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grada completed): Elementary/Secondary (0-12): / College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired): ACCOUNTANT

16b. Kind of Business/Industry: ACCOUNTING

17. Father's Name (First, Middle, Last): WILLIAM L. BOWERS, SR.

18. Mother's Name (First, Middle, Meiden Sumame): CARRIE SHOWN

19a. Informant's Name/Relationship (Type, Print): DOROTHY BOWERS/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): SAME AS ITEM #10

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or othar place): FT. LINCOLN CEMETERY

Date: 8/5/99

20c. Location - City or Town, State: BRENTWOOD, MD.

21. Signature of Funeral Servica Licensee: W.W. Chambers MOOO91

22. Name end Address of Facility: CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737

Physician /Medical Examiner

23a. Part1. Enter the disaase, or complicatians that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximata Interval Between Onset and Deeth

Immediate Ceuse (Finel disaasa or condition resulting in death): a. Ventricular Fibrillation

Due to (or es a consequence of): b. Aspiration Pneumonia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events rasulting in deeth) Last

Due to (or as a consequence of): c. Sepsis

Due to (or as a consequence of): d. Coronary Artery Disease

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: ATRIAL FIBRILLATION

23b. Did tobacco usa contributa to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Wara autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes casa referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [X] No

28d. Describe how injury occurred

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end placa, end dua to the cause(s) end manner as stated. 2 [ ] **Medical Examinar:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end piece, and due to the cause(s) and manner stated.

29b. Signature and titla of certifier: Steven Tee MD

29c. License number: D46998

29d. Date signed (Month, Day, Year): 8/2/99

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print): Steven T Tee MD 3415 Hamilton ST #1 Hyattsville MD 20782

State Registrar

31. Date filed (Month, Day, Year): AUG 03 1999

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

9+1

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: 23 PART I, PER MD G774 8-21-99 WR.

Certificate of Death

Reg. No. 99 25757

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JUNE ROSLYN BRIGGS
2. Date of Death: Month August Day 4, Year 1999
3. Time of Death: 9:50 AM
4a. Facility Name (If not institution, give street and number): 1829 Lawnview Drive
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 227-74-5074
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 59 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 28, 1940
9. Birthplace (State or Foreign Country): Trinidad

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: XX☒ Yes 2☐ No
10e. Street and Number: 1829 Lawnview Drive
10f. Zip Code: 21702
10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Library Assistant Supervisor
16b. Kind of Business/Industry: Montgomery College

17. Father's Name (First, Middle, Last): Granville Wiggins
18. Mother's Name (First, Middle, Maiden Surname): May Elaine Goodridge

19a. Interment's Name/Relationship (Type, Print): Carlton J. Briggs, husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1829 Lawnview Drive Frederick, Maryland 21702

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Resthaven Mem Gardens
Date: 8/9/99
20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service License: [signature]
22. Name and Address of Facility: Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, MD 21702

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Breast Cancer	11 YEARS
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: D29675
29d. Date signed (Month, Day, Year): August (8) 5 99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Richard Bocchino 9707 Medical Center Dr #300 Rockville, MD

State Registrar

31. Date filed (Month, Day, Year): AUG 06 1999
32. Registrar's Signature: [signature]

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25758

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
Nannie	Eleanor	BURKETT	August 04, 1999	5:55 am

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Northampton Manor Nursing Center	Frederick	Frederick

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-24-9622	1☐ M 2☒ F	92 Yrs.			Aug 6, 1906	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Frederick	Frederick	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
200 East 16th Street	21701	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8		Custodial/Housekeeping	College

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Eugene Calvin MERCER	Florence Alberta BROWN

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mrs. Eleanor A. Tyeryar/Daughter	2400 Dominion Dr, 2-B, Frederick, MD 21702

20a. Method of Disposition	20b. Place of Disposition (Name of cemetary, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Resthaven Mem Gardens	Aug 6, 1999	Frederick, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Keith Lynn Basford M00706	Keeney & Basford P.A. Funeral Home 106 E Church Street, Frederick, Maryland 21701

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cardiopulmonary Arrest	Minutes
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Organic Brain Syndrome (Alzheimer Dementia - Severe)	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☑ No	1☐ Yes 2☑ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☑ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☑ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	D50207	August 04, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Samuel Eng, M.D., 610 Solarex Court, Frederick, Maryland 21703

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
AUG 05 1999	Geneva G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #7 and #8 WCHD 8/11/99 cle *Certificate of Death*

Reg. No. 99 25759

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day	Year	3. Time of Death
HERMAN	BRADFORD	07	30	99	1220

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
PENINSULA REGIONAL MEDICAL CENTER	SALISBURY	WICOMICO

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Dey, Year)	9. Birthplace (State or Foreign Country)
214-32-6628	1☒ M 2☐ F	~~70~~ 69 Yrs.					MAR. 8, ~~1929~~ 1930	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	WICOMICO	PARSONSBURG	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
33580 ROHM RD.	21849	U.S.A.

11. Marital Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Detes:	1☐ Yes 2☒ No *Specify:*	*Specify:* WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
6		MECHANIC	TRUCKING COMPANY

17. Father's Neme (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surneme)
ERNEST LEE BRADFORD	ELIZABETH KATE GRIFFIN

19e. Informent's Neme/Relationship (Type, Print)	19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)
HELEN M. BRADFORD - WIFE	33580 ROHM RD. PARSONSBURG, MD 21849

20a. Method of Disposition	20b. Place of Disposition (Neme of cemetery, cremetory or other piece)	Dete	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	RIVERSIDE CEMETERY	8/3/99	LIBERTYTOWN, MD.

21. Signature of Funeral Service Licensee	22. Name end Address of Facility
▶ B. Kent Phippin, CFSP	705 E. MAIN ST. BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Lest

b.

Due to (or es a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobecco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were eutopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical exeminer?	26. Place of Deeth (Check only one)	
1☒ Yes 2☐ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☒ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth	28e. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify)	28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29e. Certifier (Check only one)

1☐ **Certifying Physicien:** To the best of my knowledge, deeth occurred et the time, date and place, and due to the ceuse(s) and menner es steted.

2☒ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date end piece, and due to the cause(s) end manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
▶ John T. Bulkeley D.M.E.	D0003599	07-30-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHN T. BULKELEY, M.D., 106 MILFORD ST, SUITE 201, SALISBURY MD 21804

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

10

State Registrar

31. Date filed (Month, Dey, Year)	32. Registrar's Signature
AUG 03 1999	▶ Penny G Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25760

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
RALPH	C.	BAKER	AUGUST	2	1999	3:00 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
BERLIN NURSING & REHABILITATION CENTER	BERLIN	WORCESTER

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
171-10-9511	1 [X] M 2 [ ] F	99 Yrs.					SEPT. 15, 1899	DELAWARE

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	WORCESTER	BISHOPVILLE	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
11325 BACK CREEK ROAD	21813	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
4		FARMER	POULTRY

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
ISAAC H. BAKER	BLANCHE LONG

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
JOHN E. BAKER/SON	3452 VICTOR AVENUE, BROOKHAVEN, PA 19015

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	ZION CEMETERY	8/4/99	BISHOPVILLE, MARYLAND

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Richard T. Watson	HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Acute Myocardial Infarct	hours.
Due to (or as a consequence of):	b. Coronary Artery Disease	years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c. Arteriosclerosis Diffuse	yrs.
Due to (or as a consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

History of Cerebro Vascular Accident
Chronic Obstructive Pulmonary Dis.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 [ ] Yes 2 [X] No	Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	D02026	Aug 2 99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FREDERICO ARTHES, M.D. 9715 HEALTHWAY DRIVE, BERLIN, MARYLAND 21811

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
AUG 03 1999	[signature] G Sparks

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Ralph Baker

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25756

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Betty B. Bran

2. Date of Death Month / Day / Year: July 29 1999

3. Time of Death: 2:00AM

4a. Facility Name *(If not institution, give street and number)*: North Arundel Hospital

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 578-42-0025

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Oct. 18, 1908

9. Birthplace *(State or Foreign Country)*: Russia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Riva

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 352 Berkshire Dr.

10f. Zip Code: 21140

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced — X

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No — If Yes, Give Year or Dates: X

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No — Specify: XX

14. Race - American Indian, Black, White, etc. — Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12 | College (1-4or 5+):

18a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Retail Sales

16b. Kind of Business/Industry: Private

17. Father's Name *(First, Middle, Last)*: Jacob (unknown)

18. Mother's Name *(First, Middle, Maiden Surname)*: Sarah (unknown)

19e. Informent's Name/Relationship *(Type, Print)*: Morton Baron / son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 352 Berkshire Dr. Riva, MD. 21140

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other *(Specify)* — Y

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mt. Lebanon Cemetary

Date: 8/1

20c. Location - City or Town, State: Adelphi, MD

21. Signature of Funeral Service Licensee: Michael Ziegler

22. Name end Address of Facility: Stein Hebrew Funeral Home 232 Carroll St. NW Washington, DC 20012

JW

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Infected Decubitus Ulcer

Due to (or as a consequence of): Dementia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown — YY

24a. Was an autopsy performed? 1☐ Yes 2☒ No — X

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No — X

25. Was case referred to medical examiner? 1☐ Yes 2☒ No — X

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — X | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined — X

28a. Date of Injury *(Month, Day Year)*

28b. Time of injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D45199

29d. Date signed *(Month, Day, Year)*: July 29, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Gnabajo 301 Hospital Drive Glen Burnie, MD 21061

State Registrar

31. Dete filed *(Month, Day, Year)*: AUG 04 1999

32. Registrar's Signature: Geneva G. Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificete be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25761

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Geraldine Gertrude Bridges

2. Dete of Deeth Month / Dey / Year: August 7, 1999

3. Time of Deeth: 0805 AM

4e. Feclity Neme *(If not institution, give street and number)*: 13409 Reed Road Northwest

4b. City, Town, or Location of Death: Mount Savage

4c. County of Deeth: Allegany

Funeral Director

5. Sociel Security Number: 220-10-7340

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthdey)*: 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Dey, Yeer)*: September 24, 1920

9. Birthplece *(Stete or Foreign Country)*: Maryland

Usuel Residence of Dacedent

10e. State: Maryland

10b. County: Allegany

10c. City, Town or Location: Mount Savage

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 13409 Reed Road Northwest

10f. Zip Code: 21545

10g. Citizen of Whet Country?: United States

11. Maritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondary (0-12): 11 | College (1-4or 5+):

16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Home

17. Fethar's Name *(First, Middle, Last)*: Melvin B. Reed

18. Mothar's Name *(First, Middle, Meiden Surname)*: Genieve Kelly

19e. Informent's Name/Reletionship *(Type, Print)*: Janice Harden - Daughter

19b. Mailing Address *(Street end Number or Rural Routa Number, City or Town, Stete, Zip Code)*: 252 Shawnee Avenue, Winchester, VA 22601

20e. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: St. Patrick's Church Cemetery

Dete: August 9, 1999

20c. Location - City or Town, Stete: Mount Savage, Maryland

21. Signeture of Funeral Service Licensee: Darla J. Pettigrew

22. Neme end Address of Fecility: Harvey H. Zeigler Funeral Home, Hyndman, Pennsylvania 15545

Physician /Medical Examiner

23a. Part1. Entar the diseasa, or complications that causad the deeth. Do not entar tha moda of dying, such es cardiac or respiretory errest, shock, or heert failura. List only one ceusa on aach lina.

Approximete Interval Between Onset end Deeth

Immedieta Causa (Final diseese or condition resulting in daath)
e. Respiratory Failure — 3 mnths

Dua to (or es e consequence of):
b. Chronic Obstructive lung disease — 30 years

Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Ceuse (Disaasa or Injury thet initiated evants resulting in deeth) Lest

Due to (or es e consequence of):
c. Tobacco abuse — 50 years

Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa givan in Part I.

Carcinoma lung.
Congestive heart Failure. Aortic Stenosis

23b. Did tobacco uee contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☑ No

24b. Wara autopsy findings eveileble prior to completion of ceuse of daath? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☑ No

26. Placa of Daath *(Check only ona)*: Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA — Othar: 4☐ Nursing Home 5☑ Residenca 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Deta of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1☑ **Certifying Phyeician**: To the best of my knowledge, daeth occurred et the time, date end pleca, and due to the ceuse(s) and menner as stated. 2☐ **Medical Examiner**: On the basis of examinetion end/or investigation, in my opinion, daeth occurred et tha time, data end place, and dua to the causa(s) end mannar stated.

29b. Signeture end title of certifier: SL Sandhir MD

29c. License number: D14464

29d. Date signed *(Month, Dey, Yeer)*: 8-9-1999

30. Nama and address of parson who complated causa of daath (Item 23a) (Type, Print): Dr. Sikander Lal Snadhir 48 Tarn Terr. Frostburg, MD 21532

State Registrar

31. Data filed *(Month, Dey, Yaar)*: AUG 09 1999

32. Registrar's Signeture: Donna L. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with tha Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es tha burial-transit

7

YDS

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25762

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Josephine Marie Carter
2. Date of Death Month: August Day: 4 Year: 1999
3. Time of Death: 7:45 P.M.
4a. Facility Name *(If not institution, give street and number)*: Egle Nursing Home
4b. City, Town, or Location of Death: Lonaconing
4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 213-24-5352
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 87 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: May 3, 1912
9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD
10b. County: Allegany
10c. City, Town or Location: Lonaconing
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 7 East Railroad Street
10f. Zip Code: 21539
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6 — College (1-4or 5+): 0
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Home

17. Father's Name *(First, Middle, Last)*: William Knapp
18. Mother's Name *(First, Middle, Maiden Surname)*: Ann Wilson

19a. Informant's Name/Relationship *(Type, Print)*: JoAnn Sloan daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7 E. Railroad Street, Lonaconing, MD 21539

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Cemetery St. Mary's Catholic — Date: Aug. 7 1999
20c. Location - City or Town, State: Lonaconing, MD

21. Signature of Funeral Service Licensee: John E. Miles
22. Name and Address of Facility: Eichhorn-McKenzie Funeral Home P.A. Lonaconing, MD 21539

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Cerebral Vascular Accident — 1 week

Due to (or as a consequence of):
b. Generalized Arteriosclerosis — Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Dementia - Alzheimers Type
Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: L. Miles MD
29c. License number: D07004
29d. Date signed *(Month, Day, Year)*: Aug. 5, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): L.R. MILES, JR., M.D. 57 JACKSON ST. LONACONING MD 21539

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 0 6 1999
32. Registrar's Signature: Barbara P. Hanks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25763

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jaime Calangan, Sr.

2. Date of Death: Month July Day 28 Year 1999

3. Time of Death: 2229 PM

4a. Facility Name (If not institution, give street and number): SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 213-96-4705

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 50 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 22, 1949

9. Birthplace (State or Foreign Country): Philippines

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Gaithersburg

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 426 Girard Street #201

10f. Zip Code: 20877

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Asian

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Administrator

16b. Kind of Business/Industry: Food Store

17. Father's Name (First, Middle, Last): Emilio Calangan

18. Mother's Name (First, Middle, Maiden Surname): Violet Aliangan

19a. Informant's Name/Relationship (Type, Print): Connie P. Calangan (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 426 Girard Street #201 Gaithersburg, Maryland 20877

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cemetery

Date: 8/2/99

20c. Location - City or Town, State: Silver Spring, Maryland

21. Signature of Funeral Service Licensee: Robert E Ramsey

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Ventricular fibrillation	sec
Due to (or as a consequence of): b.	Acute myocardial infarction	min
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last. Due to (or as a consequence of): c.	Status Asthmaticus	2 hours
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Thai Mg MD

29c. License number: D47093

29d. Date signed (Month, Day, Year): July 28, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Martin Thai MCanelvy 9901 Medical Ctr Drive Rockville MD

State Registrar

31. Date filed (Month, Day, Year): AUG 02 1999

32. Registrar's Signature: Jenna G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25764

Physician /Medical Examiner

1. Decedent's Nema *(First, Middle, Last)*: Aldo Camana

2. Data of Death Month Day Yaar: July 29, 1999

3. Tima ot Death: 1:00AM

4a Facility Nama *(If not institution, giva street and number)*: 2115 GATEWOOD PLACE

4b. City, Town, or Location of Death: SILVER SPRING

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Sacurity Number: 578-18-5210

6. Sex: XX M 2☐ F

7. Age *(In yrs. last birthday)*: 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: MAY 3, 1920

9. Birthplaca *(Stata or Foraign Country)*: TURINO, ITALY

Usual Rasidence of Decedant

10a. Stata: MARYLAND

10b. County: MONTGOMERY

10c. City, Town or Location: SILVER SPRING

10d. Insida City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 2115 GATEWOOD PLACE

10f. Zip Code: 20904

10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☐ Navar Married 2☐ Married 3XX Widowed 4☐ Divorcad

12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yas XX No *Specify:*

14. Race - American Indian, Black, Whita, atc. *Specify:* WHITE

15. Decedant's Education *(Specify only highast grada completed)*: Elamentary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work done during most of working lifa. DO NOT use retired)*: ADMINISTRATIVE OFFICER

16b. Kind of Business/Industry: FED. GOV'T

17. Father's Nama *(First, Middle, Last)*: GIOVANI CAMANA

18. Mother's Name *(First, Middle, Maidan Sumama)*: LOUISA (LUIGIA) CAMPASSO

19a. Intorment's Name/Ralationship *(Type, Print)*: LYDIA VANCE DAUGHTER

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3102 CORLEAR DR. BALDWINSVILLE NY. 13027

20a. Mathod of Disposition: 1☐ Burial 2☒ Cramation 3☐ Removal from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Place of Disposition *(Nama of cematary, crematory or other place)*: FT. LINCOLN CREMATORY | Data: 7-31-99

20c. Location - City or Town, Stata: BRENTWOOD, MARYLAND

21. Signature of Funeral Service Licensee: Louis L. Grant

22. Nama and Addrass of Facility: HINES-RINALDI F.H. INC. 11800 NEW HAMPSHIRE AVE. SILVER SPRING, MD.

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that caused tha daath. Do not entar tha mode of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only ona causa on aach lina.

Approximata Intarval Batwaan Onsat and Death

Immediata Ceusa (Final disaasa or condition resulting in daath)
a. SQUAMOUS CELL CARCINOMA LEFT EAR — 5YRS

Due to (or as a consequence of):

Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disaasa or Injury that initiatad events resulting in daath) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ADULT ONSET DIABETES

HYPERTENSION

23b. Did tobacco use contributa to the cause of death? 1☒ Yas 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Were autopsy findings available prior to compiation of causa of death? 1☐ Yas 2☐ No

25. Was casa ratarrad to medical examiner? XX Yas 2☐ No

26. Place of Death *(Check only ona)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatiant 3☐ DOA | Other: 4☐ Nursing Homa 5☒ Rasidance 6☐ Othar *(Specify)*

27. Manner ot Daath: XX 1☐ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Pending investigation 6☐ Could not be determined

28a. Dete ot Injury *(Month, Day Year)* | 28b. Tima of Injury | 28c. Injury at Work? 1☐ Yas 2☐ No | 28d. Dascribe how injury occurred

28a. Place of Injury - At homa, farm, street, factory, office building, atc. *(Specify)* | 28f. Location *(Street and Number or Rural Route Number, City or Town, Stata)*

29a. Certifiar *(Check only one)*: XX **Certifying Physician:** To tha best of my knowladge, death occurrad at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurrad at the tima, data and place, and due to the cause(s) and mannar stated.

29b. Signature and title of certifier: Michael A. Bolognese M.D.

29c. License number: A24034

29d. Data signed *(Month, Day, Year)*: 7/30/99

30. Nama and addrass of person who completed cause of daath (Item 23a) (Type, Print): Michael Bolognese M.D. 10215 Fernwood Rd. #40 Bethesda, MD. 20817

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 03 1999

32. Registrar's Signatura: Donna G. Sparks

DHMH 16 Rav 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25765

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
A. George Carlton	August 4 1999	4:28AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Washington Adventist Hospital	Takoma Park	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
473-07-4980	1☒ M 2☐ F	82 Yrs.			Feb. 14 1917	Minnesota

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Montgomery	Silver Spring	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
301 East Wayne Avenue	20901	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	5+	Statistician	Research

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Ernest Conrad Carlton	Lois Olive Treadwell

19a. Informent's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Martha Carlton (wife)	301 East Wayne Avenue, Silver Spring MD 20901

20a. Method of Disposition	20b. Place of Disposition (Name of cemetary, cramatory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cramation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Metropolitan Crematory	8-6-99	Alexandria, VA

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ J. Kevin Slicker	Francis J. Collins Funeral Home 500 University Blvd. W. Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failura. List only ona cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. RESPIRATORY FAILURE	24 h
	Due to (or es e consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initialed events resulting in death) Last	b. ASPIRATION PNEUMONIA	48 h
	Due to (or es a consequence of):	
	c.	
	Dua to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

CHRONIC OBSTRUCTIVE LUNG DIS.

CONGESTIVE HEART FAILURE

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of causa of deelh?
1☐ Yes 2☑ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☑ No	Hospitel: 1☑ Inpatiant 2☐ ER/Outpatiant 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2☐ **Medical Examiner:** On the besis of examinetion and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Data signed (Month, Day, Year)
▶ E Africano M.D.	D-19400	8-4-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ERNESTO AFRICANO, M.D. 831 UNIVERSITY BLV. SILVER SPRING, MD.

State Registrar

31. Dete filed (Month, Day, Year)	32. Registrar's Signature
AUG 06 1999	▶ Geneva G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet tha death certificata be axecuted within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, pege 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25766

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Lois Jean Cherba
2. Date of Death (Month, Day, Year): August 2, 1999
3. Time of Death: 12:15 PM
4a. Facility Name *(If not institution, give street and number)*: Suburban Hospital
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 195-30-0077
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 60 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: April 27, 1939
9. Birthplace *(State or Foreign Country)*: Pennsylvania

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Potomac
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 10412 Gainsborough Road
10f. Zip Code: 20854
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Administrative Assistant
16b. Kind of Business/Industry: Retirement Home

17. Father's Name *(First, Middle, Last)*: Charles Zehnder
18. Mother's Name *(First, Middle, Maiden Surname)*: Lillian Cetto

19a. Informant's Name/Relationship *(Type, Print)*: Michael Cherba/Husband
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 10412 Gainsborough Road, Potomac, Maryland 20854

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Parklawn Memorial Park — Date: Aug. 5, 1999
20c. Location - City or Town, State: Rockville, Maryland

21. Signature of Funeral Service Licensee: Robert Fawcett M00198
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Liver failure	2 months
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Breast cancer	9 years
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Sepsis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Leon Hwang MD
29c. License number: D45880
29d. Date signed *(Month, Day, Year)*: 8/2/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Leon Hwang, M.D. 10400 Connecticut Avenue, Kensington, Maryland 20895

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 05 1999
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020
Division of Vital Records, P.O. Box 68760,

Cherba, Lois 08/02/99 12:15 PM

(B) 12

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25767

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: RICHARD PATTON CLIME
2. Date of Death Month / Day / Year: AUGUST 3 / 1999
3. Time of Death: 1945PM
4a. Facility Name *(If not institution, give street and number)*: SHADY GROVE ADVENTIST HOSPITAL
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 217-36-9430
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 57 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: AUG. 4, 1941
9. Birthplace *(State or Foreign Country)*: WASHINGTON, DC

Usual Residence of Decedent

10a. State: MD
10b. County: MONTGOMERY
10c. City, Town or Location: SILVER SPRING
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 8 SOUTHVIEW COURT
10f. Zip Code: 20905
10g. Citizen of What Country?: USA

11. Meritel Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Raca - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12 — College (1-4or 5+): 3
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: SELF EMPLOYED
16b. Kind of Business/Industry: CONTRACTOR

17. Father's Name *(First, Middle, Last)*: ARTHUR CLIME
18. Mother's Name *(First, Middle, Meiden Sumeme)*: RUTH PATTON

19e. Informent's Name/Relationship *(Type, Print)*: LINDA CLIME (SPOUSE)
19b. Malling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8 SOUTHVIEW COURT SILVER SPRING, MD 20905

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: FORT LINCOLN CREMATORY
Date: 8-5-99
20c. Location - City or Town, Stete: BRENTWOOD, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: HINES-RINALDI 11800 NEW HAMPSHIRE AVENUR SILVER SPRING, MARYLAND 20904

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in deeth)
a. ADENOCARCINOMA OF UNKNOWN PRIMARY SITE — 1 WEEK

Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes cese referred to medical exeminer? 1 [ ] Yes 2 [X] No
26. Plece of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Menner of Deeth: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Dete of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner stated.
29b. Signeture end title of certifier: James G. Brown, MD
29c. License number: D07285
29d. Date signed *(Month, Dey, Year)*: AUGUST 4, 1999
30. Name and address of person who completed ceuse of deeth (Item 23e) (Type, Print): JAMES A BROWN, MD 9707 MEDICAL CENTER DRIVE, ROCKVILLE, MARYLAND 20850

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 06 1999
32. Registrer's Signeture: Geneva G. Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that this death certificate be executed within 24 hours after death.
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Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

99-4483-031
jhm
LILA DENISE TERRY COBB

AMEND ITEMS: #23 PART I, 27, 28A-F PER MEO C778 12-7-99 WR.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25768

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Lila Denise Terry Cobb	JULY 30, 1999	10:35 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
1212 EAST WEST HIGHWAY	SILVER SPRING	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
227-96-8060	1☐ M 2☒ F	41 Yrs.			March 21, 1958	Wisconsin

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Unknown	Unknown	Unknown	1☐ Yes 2☐ No Unknown

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
Unknown	Unknown	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	2	Various Jobs	Office Work

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John Henry Terry	Ivana Henderson

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Helen H. McMurray (aunt)	900 North Taylor Street, #709W, Arlington, VA 22203

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Chesapeake Crematory	8-2-99	Beltsville, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Ellen W. Rapp	Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

(B)

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. NORTRIPTYLINE INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒ Yes 2☐ No	1☒ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒ Yes 2☐ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) SCENE

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐ Natural 2☐ Accident 3☒ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined	Found: 7:30-99	UNKNOWN AM	1☐ Yes 2☒ No	SUBJECT INGESTED DRUG

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
FOUND IN AUTO	1212 EAST W. HWY SILVER SPRING, MD

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ J. Laron Locke MD	OCME	JULY 31, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. LARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
AUG 02 1999	▶ Donna G. Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

3

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25769

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JAMES DAVID COOK III
2. Date of Death: Month AUG. Day 3, Year 1999
3. Time of Death: 6:40 PM
4a. Facility Name (If not institution, give street and number): 5999 EMERSON ST. #210
4b. City, Town, or Location of Death: BLADENSBURG
4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 212-48-8079
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 51 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): NOV. 19, 1947
9. Birthplace (State or Foreign Country): MISSISSIPPI

Usual Residence of Decedent

10a. State: MD.
10b. County: PRINCE GEORGES
10c. City, Town or Location: BLADENSBURG
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 5999 EMERSON ST. #210
10f. Zip Code: 20710
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: APR. 1967 - MAY 1967
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Specify kind of work done during most of working life. DO NOT use retired): FILE CLERK
16b. Kind of Business/Industry: H.U.D.

17. Father's Name (First, Middle, Last): JAMES DAVID COOK, II
18. Mother's Name (First, Middle, Maiden Surname): JOY ZELMA JOHNS

19a. Informant's Name/Relationship (Type, Print): DOROTHY A. BOND/EX-WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4605 EDMONSTON RD., HYATTSVILLE, MD. 20781

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): CHAMBERS CREMATORY
Date: 8/11/99
20c. Location - City or Town, State: RIVERDALE, MD.

21. Signature of Funeral Service Licensee: W. W. Chambers MOOO91
22. Name and Address of Facility: CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. Dehydration
Due to (or as a consequence of):
b. Malnutrition
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c. Muscular Dystrophy
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [✓] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Louis Steinberg MD
29c. License number: D12015
29d. Date signed (Month, Day, Year): 8/4/1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Louis E. Steinberg, M.D. 6492 Landover Road, Landover, MD 20785

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): AUG 06 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Amended item #5, per F.D. 8/4/99, Carroll County, cew

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25770

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: GLADYS COOPER

2. Date of Death Month: JULY Day: 29 Year: 99

3. Time of Death: 9:35am

4a. Facility Name *(If not institution, give street and number)*: COPPER RIDGE

4b. City, Town, or Location of Death: SYKESVILLE

4c. County of Death: CARROLL

Funeral Director

5. Social Security Number: ~~159-07-4299~~ 209-34-1266

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 87 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Nov. 10, 1911

9. Birthplace *(State or Foreign Country)*: PA

Usual Residence of Decedent

10a. State: MD

10b. County: CARROLL

10c. City, Town or Location: SYKESVILLE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 710 OBRECHT ROAD

10f. Zip Code: 21784

10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☐ Naver Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yas, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indien, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work dona during most of working life. DO NOT use retired)*: HOMEMAKER

16b. Kind of Business/Industry: DOMESTIC

17. Fathar's Nama *(First, Middla, Last)*: MICHAEL GALLAGHER

18. Mother's Neme *(First, Middle, Meiden Sumeme)*: MELCINO SCHLICTER

19a. Informant's Name/Relationship *(Type, Print)*: WENDY COOPER/DAUGHTER

19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 358 E. HILLENDALE ROAD, KENNETT SQUARE, PA 19348

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other pleca)*: CARROLL CREMATORY Date: 7/30/99

20c. Location - City or Town, State: HAMPSTEAD, MD

21. Signature of Funeral Service Licensee: Jennifer L. Scherr

22. Name and Addrass of Fecility: MYERS FUNERAL HOME 91 WILLIS STREET WESTMINSTER, MD 21157

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one causa on each line.

Approximate Interval Between Onsat and Death

Immediate Causa (Final disease or condition resulting in death): a. DEMENTIA — 4 YEARS

Due to (or as a consequenca of):

Sequentially list conditions, if any, laading to immadiate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest

b. Due to (or as a consequence of):

c. Dua to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings availeble prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: ☒ Nursing Home 5☐ Residence 6☐ Othar *(Specify)*

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or Investigetion, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ernestine Wright MD

29c. Licanse number: D52740

29d. Data signed *(Month, Day, Year)*: 7/29/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ernestine Wright MD Copperridge, Sykesville, MD 710 Obrecht ROAD

State Registrar

31. Date filed *(Month, Dey, Year)*: JUL 30 1999

32. Registrar's Signature: Donna G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25771

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EUGENE DARBY CARNEY

2. Date of Death (Month, Day, Year): JULY 30, 1999

3. Time of Death: 7:31 A.M.

4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 214-22-3172

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 73 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 17, 1925

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 5590 Teakwood Court

10f. Zip Code: 21703

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1943-1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher

16b. Kind of Business/Industry: Education

17. Father's Name (First, Middle, Last): Eugene Darby CARNEY

18. Mother's Name (First, Middle, Maiden Surname): Mildred LERUE

19a. Informant's Name/Relationship (Type, Print): Mrs. Suzanne E. Carney, Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5590 Teakwood Court, Frederick, Md. 21703

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify) Entombment

20b. Place of Disposition (Name of cemetery, cremetory or other place) | Date: Mount Olivet Cemetery, Aug. 2, 1999

20c. Location - City or Town, State: Frederick, Md.

21. Signature of Funeral Service Licensee: ▶ Richard E. Graf M00255

22. Name and Address of Facility: Keeney and Basford P.A. Funeral Home, 106 East Church St., Frederick, Md. 21701

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Hypoxemia	minutes
Due to (or as a consequence of): b.	Pneumonitis	minutes
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last. Due to (or as a consequence of): c.	Aspiration	intermittent
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

END STAGE RENAL DISEASE

DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? 1 [ ] Yes 2 [ ] No | 28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Mark P. Rubin, MD

29c. License number: D28575

29d. Date signed (Month, Day, Year): 7/30/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARK P. RUBIN MD 201 Thomas Johnson Dr. FREDERICK MD 21702

State Registrar

31. Date filed (Month, Day, Year): AUG 02 1999

32. Registrar's Signature: ▶ Denise G. Spaar

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25772

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Nettie Mabel Cosgrove
2. Date of Death (Month, Day, Year): August 2, 1999
3. Time of Death: 6:30 pm
4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 212-14-7685
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 78 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 22, 1921
9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1100 Poplar Street
10f. Zip Code: 21702
10g. Citizen of What Country?: United States
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Owner and Operator
16b. Kind of Business/Industry: Restaurant
17. Father's Name (First, Middle, Last): Charles E. Jacobs
18. Mother's Name (First, Middle, Maiden Surname): Minnie Stubs
19a. Informant's Name/Relationship (Type, Print): Thomas Harding, son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1100 Poplar Street Frederick, Maryland 21702
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Olivet Cemetery
Date: 8/6/99
20c. Location - City or Town, State: Frederick, Maryland
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, Maryland 21702

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Acute Renal Failure — Days

Due to (or as a consequence of):
b. Sepsis — Days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c. Myasthenia Gravis — Months

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Chronic obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M Tolino MD
29c. License number: MD51610
29d. Date signed (Month, Day, Year): 8-2-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 1475 Taney Ave Suite 204 Frederick, MD 21702

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): AUG 04 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25773

Certificate of Death Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARGARET ANN CALAME
2. Date of Death: Month July Day 30 Year 1999
3. Time of Death: 1022
4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER
4b. City, Town, or Location of Death: SALISBURY
4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 214-28-8511
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 67 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 11, 1932
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Wicomico
10c. City, Town or Location: Fruitland
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 226 Sandcastle Blvd.
10f. Zip Code: 21826
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+): –
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Domestic

17. Father's Name (First, Middle, Last): Charles Morris
18. Mother's Name (First, Middle, Maiden Surname): Mable Thomas

19a. Informant's Name/Relationship (Type, Print): April Y. Calame-Brenner/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 226 Sandcastle Blvd., Fruitland, MD 21826

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Salisbury Crematory
Date: 7/31/99
20c. Location - City or Town, State: Salisbury, MD

21. Signature of Funeral Service Licensee: Ray Holloway
22. Name and Address of Facility: Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Respiratory Failure

Due to (or as a consequence of):
b. Severe COPD

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c. (2) lung mass prob carcinoma

Due to (or as a consequence of):
d. Ventilator dependence 2° Evisceration

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Evisceration 2° necrosis of ventral incisional hernia, NIDDM, HTN chronic steroid use, Hx of ulcer disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D33796
29d. Date signed (Month, Day, Year): 7/30/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David Walker 560 Riverside Dr. A206 Salisbury, md 21801

State Registrar

31. Date filed (Month, Day, Year): AUG 02 1999
32. Registrar's Signature: Donna G Sparks

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Margaret Calame 214-28-8511

DHMH 16 Rev 6/95

99-4461-045
crn
Austin Paul Cooper

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25774

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): AUSTIN PAUL COOPER
2. Date of Death (Month, Day, Year): July 28, 1999
3. Time of Death: 5:50 P.M.
4a. Facility Name (If not institution, give street and number): 34756 Casher-Wells Road
4b. City, Town, or Location of Death: Pittsville
4c. County of Death: Wicomico

Funeral Director

5. Social Security Number: 220-12-2330
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 73 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): APRIL 18, 1926
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: WICOMICO
10c. City, Town or Location: WILLARDS
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 36046 RICHLAND ROAD
10f. Zip Code: 21874
10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 4 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LUMBERMAN
16b. Kind of Business/Industry: LUMBER

17. Father's Name (First, Middle, Last): WILLIAM S. COOPER
18. Mother's Name (First, Middle, Maiden Surname): ELIZABETH LITTLETON

19a. Informant's Name/Relationship (Type, Print): MARY F. TIMMONS/NIECE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 34324 WANGO ROAD, PARSONSBURG, MARYLAND 21849

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): NEW HOPE CEMETERY
Date: 8/1/99
20c. Location - City or Town, State: WILLARDS, MARYLAND

21. Signature of Funeral Service Licensee: Charles W Hastings
22. Name and Address of Facility: HASTINGS FUNERAL HOME, SELBYVILLE, DE 19975

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Compromised Asphyxia + Multiple Injuries
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) at scene

27. Manner of Death: 1 [ ] Natural 2 [XX] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year): Found 7/28/99
28b. Time of Injury: 1637 HRS M
28c. Injury at Work? 1 [X] Yes 2 [ ] No
28d. Describe how injury occurred: Subject pinned by equipment
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Worksite
28f. Location (Street and Number or Rural Route Number, City or Town, State): 34756 Casher-Wells Road Pittsville Maryland

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [XX] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Theodore M. Kiningham
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): July 29, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THEODORE McKINGHAM 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): AUG 03 1999
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25775

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): VICTORIA M. DeMAR

2. Date of Death (Month, Day, Year): JULY 24, 1999

3. Time of Death: 4:50 AM

4a. Facility Name (If not institution, give street and number): SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: Unknown

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 43 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 17,1956

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedant

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Gaithersburg

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 9237 Bluebird Terrace

10f. Zip Code: 20879

10g. Citizen of What Country?: U.S.A.

11. Marital Status: ☒ 1 Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes ☒ 2 No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9th | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa ratired): Homemaker

16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): James C. DeMar

18. Mothar's Name (First, Middle, Meiden Surname): Lucille E. Dorsey

19a. Informant's Name/Relationship (Type, Print): James C. DeMar (Father)

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 19229 Esmond Ter., Germantown, MD 20874

20a. Mathod of Disposition: ☒ 1 Burial 2☐ Cramation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crametory or other piece): Lincoln Park Cemetery | Date: 7/30/99

20c. Location - City or Town, State: Rockville, MD

21. Signature of Funeral Service Licensee: George K. Snowden

22. Name and Address of Facility: SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850

Physician /Medical Examiner

23a. Part1. Entar l disaasa, or complications that ceusad tha daath. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or hea failure. List only one causa on each line.

Approximate Interval Between Onset and Death

Immediata Causa (Final disease or condition resulting in death)

a. METASTATIC CERVICAL CANCER

Dua to (or as a consequance of):

b. PNEUMONIA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. RESPIRATORY FAILURE

Due to (or as a consequence of):

d. SEPSIS

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes ☒ 2 No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes ☒ 2 No

24b. Wara autopsy findings available prior to completion of cause of death? 1☐ Yes ☒ 2 No

25. Was case referred to medical examiner? 1☐ Yes ☒ 2 No

26. Place of Death (Check only one): Hospital: ☒ 1 Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: H51280

29d. Date signed (Month, Day, Year): 07-25-11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ANUSH DAGGAR 13219 EXECUTIVE PARK TERRACE GERMANTOWN, MD 20874

State Registrar

31. Date filed (Month, Day, Year): AUG 03 1999

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

RKD ,
99-4420-031
CHARLES
DAVIS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25776

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CHARLES R. DAVIS, JR
2. Date of Death (Month, Day, Year): JULY 26, 1999
3. Time of Death: 4:22 PM
4a. Facility Name (If not institution, give street and number): SHADY GROVE ADVENTIST HOSPITAL
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 214-86-0393
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 23 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 7, 1975
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 709 Lenmore Ave., #C-24
10f. Zip Code: 20850
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11th | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: Construction
17. Father's Name (First, Middle, Last): Charles R. Davis, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Evelyn M. McRoy
19a. Informant's Name/Relationship (Type, Print): Evelyn McRoy (Mother)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 709 Lenmore Ave., #24C, Rockville, MD 20850
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Lincoln Park Cem.
Date: 8/5/99
20c. Location - City or Town, State: Rockville, MD
21. Signature of Funeral Service Licensee: George R. Snowden
22. Name and Address of Facility: SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Hanging	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [X] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year): Found 7-26-99
28b. Time of Injury: Found 1520 M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: subject hanged self
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): PRISON
28f. Location (Street and Number or Rural Route Number, City or Town, State): Montgomery County Detention Center, Md

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dennis J. Chute MD
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): JULY 27, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dennis J. Chute, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): AUG 03 1999
32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25777

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Yucai Daio
2. Data of Death Month Day Yaar: July 29, 1999
3. Time of Death: 5:46 PM
4a. Facility Name (If not institution, giva street and number): Shady Grove Adventist Hospital
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 216-43-6171
6. Sex: 1☒ M 2☐ F
7. Aga (In yrs. last birthday): 61 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): May 22, 1938
9. Birthplace (Stata or Foraign Country): China

Usual Residenca of Decedant

10a. Stata: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1☒ Yas 2☐ No
10e. Street end Number: 1001 Rockville Pike, #102
10f. Zip Coda: 20852
10g. Citizan of What Country?: China

11. Marital Status: 1☐ Navar Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedant Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yas, Giva Yeer or Datas:
13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1☐ Yas 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Chinese

15. Decedant's Education (Specify only highast grada completad): Elamantary/Secondary (0-12): ; College (1-4or 5+): 5
16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired): Electrical Engineer
16b. Kind of Business/Industry: Communications

17. Fathar's Nama (First, Middle, Last): Unavailable
18. Mother's Name (First, Middle, Maidan Sumama): Unavailable

19a. Informant's Name/Relationship (Type, Print): Sheila S. Xu (wife)
19b. Mailing Address (Straat and Number or Rural Route Number, City or Town, State, Zip Code): Same as 10

20a. Mathod of Disposition: 1☐ Burial 2☒ Cramation 3☐ Ramoval from Stata 4☐ Donetion 5☐ Othar (Specify)
20b. Placa of Disposition (Nama of cemetery, cramatory or other place): Chesapeake Crematory
Data: 7-31-99
20c. Location - City or Town, Stata: Beltsville, Maryland

21. Signature of Funeral Sarvice Licensee: Elan H. Rapp
22. Nama and Address of Facility: Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910

Physician /Medical Examiner

23a. Part1. Enter tha disaasa, or complications that causad tha daath. Do not anter tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach lina.

Approximata Interval Between Onset and Death

Immediate Cause (Final diseasa or condition rasulting in death): a. Metastatic Non-small Cell Lung Cancer — 2 years

Due to (or as e consequance of):

Sequentially list conditions, if any, leading to immadiate causa. Entar Underlying Cause (Disease or Injury that initiated events resulting in death) Lest:
b.
Dua to (or as a consaquanca of):
c.
Dua to (or as a consaquance of):
d.

Part II. **Other significant conditions** contributing to daath but not rasulting in tha underlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performad? 1☐ Yas 2☒ No

24b. Were autopsy findings available prior to completion of causa of daath? 1☐ Yes 2☒ No

25. Was casa rafarrad to madical axaminar? 1☐ Yas 2☒ No

26. Piece of Death (Check only ona): Hospital: 1☒ Inpatiant 2☐ ER/Outpatiant 3☐ DOA Other: 4☐ Nursing Homa 5☐ Residence 6☐ Othar (Specify)

27. Manner of Daath: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending Investigation 6☐ Could not ba datarminad

28a. Date of Injury (Month, Day Year)
28b. Tima of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, straat, factory, office building, atc. (Spacify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Cartifiar (Check only one): 1☒ **Certifying Physician**: To the bast of my knowledga, daath occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Madical Examiner**: On tha basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and placa, and dua to the cause(s) and mannar stated.

29b. Signature and title of cartifiar: Joseph Kaplan
29c. Licansa number: D 35635
29d. Data signed (Month, Day, Year): July 30, 1999

30. Nama and address of parson who completed causa of daath (Item 23e) (Type, Print): Joseph Kaplan, M. D., 18111 Prince Philip Drive, #327, Olney, MD 20832

State Registrar

31. Data filed (Month, Day, Year): AUG 02 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25778

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): David Michael Dantzic
2. Date of Death: Month August, Day 2, Year 1999
3. Time of Death: 9:29 AM
4e. Facility Name (If not institution, give street and number): 1111 Notley Road
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 215-36-4689
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 59 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): Feb.27,1940
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1111 Notley Road
10f. Zip Code: 20904
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12); College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Assistant Director of Transportation
16b. Kind of Business/Industry: Jewish Social Services

17. Father's Name (First, Middle, Last): David Myer Dantzic
18. Mother's Name (First, Middle, Maiden Surname): Villa Redman

19a. Informant's Neme/Reletionship (Type, Print): David Myer Danzic, II (son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 625 Grant Place Frederick,Maryland 21702

20a. Method of Disposition: 1☐ Buriel 2☑ Cremetion 3☐ Removel from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory
Date: 8/3/99
20c. Location - City or Town, Stete: Alexandria,Virginia

21. Signature of Funeral Service Licensee: Eric S. Scrbo
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd.,W.,Silver Spring,MD 20901

Physician /Medical Examiner

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. cirrhosis liver
Due to (or as a consequence of):
DME

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ira N Brecher MD OME
29c. License number: D00428
29d. Date signed (Month, Day, Year): Aug 2, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): IRA N BRECHER, MD OME 2101 Medical Pkwy Silver Spring MD 20902

State Registrar

31. Date filed (Month, Dey, Year): AUG 03 1999
32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

(5)

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

-7+1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25779

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LEWIS COLEN DIXON
2. Date of Death (Month, Day, Year): July 27, 1999
3. Time of Death: 6:30 A.M.
4a. Facility Name (If not institution, give street and number): 509 South Main Street
4b. City, Town, or Location of Death: Mt. Airy
4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 237-22-6041
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 19, 1922
9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Maryland
10b. County: Carroll
10c. City, Town or Location: Mt. Airy
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 509 South Main Street
10f. Zip Code: 21771
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever In U.S. Armed Forces? [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mechanical Engineer
16b. Kind of Business/Industry: Federal Government

17. Father's Name (First, Middle, Last): Victor Colen Dixon
18. Mother's Name (First, Middle, Maiden Surname): Lora Griffin

19a. Informant's Name/Relationship (Type, Print): Beverly L. Ayres Dixon, wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 509 S. Main Street Mt. Airy, Maryland 21771

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Pine Grove Cemetery
Date: 7/31/99
20c. Location - City or Town, State: Mt. Airy, Maryland

21. Signature of Funeral Service Licensee: Penny R. Sawyer
22. Name and Address of Facility: Stauffer Funeral Homes, P.A. 8 East Ridgeville Blvd. Mt. Airy, MD 21771

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. WALDENSTROMS MACROGLOBULINEMIA — 10-15 YEARS

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I: DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier: MD
29c. License number: 026499
29d. Date signed (Month, Day, Year): 7-27-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Ronald Miller, M.D. 4 Culwell Drive Mt Airy, MD 21771

State Registrar

31. Date filed (Month, Day, Year): JUL 29 1999
32. Registrar's Signature: B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25780

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ELIZABETH LILLIE DIEHL

2. Date of Death: Month AUGUST Day 4 Year 1999

3. Time of Death: 12:05 PM

4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 219-20-4960

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 75 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 25, 1924

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.

10b. County: Washington

10c. City, Town or Location: Knoxville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 824 Weverton Road

10f. Zip Code: 21758

10g. Citizen of What Country?: USA

11. Meritel Stetus: 1☐ Never Married 2☐ Merried 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 8; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Owner

16b. Kind of Business/Industry: Grocery Store

17. Father's Neme (First, Middle, Last): Melvin William Phillips

18. Mother's Name (First, Middle, Maiden Surname): Catherine Elizabeth Olden

19a. Informant's Name/Reletionship (Type, Print): Pauline C. Lawson, Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10517 Brenda Avenue - Ijamsville, MD 21754

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Brownsville Heights Cem.

Date: 8/8/99

20c. Location - City or Town, State: Brownsville, MD

21. Signature of Funeral Service Licensee: Robert L. Spencer

22. Name and Address of Facility: Eackles-Spencer Funeral Home, Harpers Ferry, WV 25425

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on eech line.

Approximete Intervel Between Onset and Death

Immediete Ceuse (Final disease or condition resulting in death)
a. Myocardial Infarction — Minutes

Due to (or as a consequence of):
b. Atherosclerotic Heart Disease — years

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

Due to (or as a consequence of):
c. Hypertension — years

Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Hyperlipidemic

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signeture and title of certifier: MD

29c. License number: D47556

29d. Date signed (Month, Day, Year): 8/5/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): WILLIAM JOHNSON, 172 THOMAS JOHNSON DRIVE, FREDERICK MD 21702

State Registrar

31. Dete filed (Month, Day, Year): AUG 06 1999

32. Registrar Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25781

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Catherine Dora Dale	7 / 28 / 99	0353

4e. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
PENINSULA REGIONAL MEDICAL CENTER	SALISBURY	WICOMICO

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-14-6045	1☐ M 2☒ F	76 Yrs.			Nov. 14 1922	Maryland

Usual Residence of Decedent

10e. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Wicomico	Salisbury	1☐ Yes 2☒ No

10e. Street end Number	10f. Zip Code	10g. Citizen of What Country?
423 Patrick Avenue	21801	U.S.A

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8		Domestic	None

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John Corbin	Susan Wilson

19e. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Chester Dale	423 Patrick Ave. Salisbury, Md. 21801

20e. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Springhill Mem. Garden	8/2/99	Salisbury, Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Gladys B. Stewart	Stewart Funeral Home 821 West Rd. Salisbury, Md. 21801

Physician /Medical Examiner

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Sepsis	1wk
Due to (or as a consequence of):	b. right lobar pneumonia	1wk
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

renal failure, respiratory failure, atrial fibrillation, history of prednisone-dependent arthritis, diabetes, peripheral vascular disease

23b. Did **tobacco use** contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Janet Wasson	44979	7/28/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
JANET WASSON, M.D. 145 E. Carroll St. Salisbury, MD 21801

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 29 1999	▶ [signature] B Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

Dale, Catherine 213 14 6045

3

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25782

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ELIZABETH KATHRYN DOWNES
2. Data of Death (Month, Day, Year): July 26, 1999
3. Time of Death: 9:50 PM
4a. Facility Name (If not institution, give street and number): 6361 Culver Rd.
4b. City, Town, or Location of Death: Salisbury
4c. County of Death: Wicomico

Funeral Director

5. Social Security Number: 214-10-8741
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 88 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): July 15, 1911
9. Birthplace (State or Foreign Country): Delaware

Usual Residence of Decedent

10a. State: Maryland
10b. County: Wicomico
10c. City, Town or Location: Salisbury
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 6361 Culver Rd
10f. Zip Code: 21801
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4or 5+): -
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Domestic

17. Father's Name (First, Middle, Last): John Henry Quillen Jr.
18. Mother's Name (First, Middle, Maiden Surname): Mary Elizabeth Bowden

19a. Informant's Name/Relationship (Type, Print): Walter W. Downes/Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6361 Culver Rd., Salisbury, MD 21801

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Springhill Memory Gardens
Data: 7/30/99
20c. Location - City or Town, State: Hebron, MD

21. Signature of Funeral Service Licensee: ▶ W. R. Holloway CFSP
22. Name and Address of Facility: Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Parkinsons disease
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Rodney A. Wenrich, M.D.
29c. License number: D 15384
29d. Date signed (Month, Day, Year): 7/28/99

12
(Kdj)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RODNEY A. WENRICH 100 POWER ST. SALISBURY MD. 21804

State Registrar

31. Date filed (Month, Day, Year): JUL 28 1999
32. Registrar's Signature: Donna G Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25783

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Rosa (nmn) DiCara
2. Date of Death Month: July Day: 31 Year: 1999
3. Time of Death: 2:55 PM
4a. Facility Name (If not institution, give street and number): Mariner Health of Forest Hill
4b. City, Town, or Location of Death: Forest Hill
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 040-26-4071
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 98 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 30, 1901
9. Birthplace (State or Foreign Country): Italy

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Bel Air
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 104 Glenwood Rd.
10f. Zip Code: 21014
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 3 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Fether's Neme (First, Middle, Last): Domenico (nmn) Nicolosi
18. Mother's Neme (First, Middle, Maiden Surname): Nunziata (nmn) LaRosa

19a. Informant's Neme/Reletionship (Type, Print): Nunziata Runci - Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 104 Glenwood Rd., Bel Air, MD 21014

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Riverside Cemetery
Dete: 8-3-99
20c. Location - City or Town, State: Old Saybrook, CT

21. Signature of Funeral Service Licensee: Fernando R. Mc Comas II
22. Name end Address of Fecility: McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heert failure. List only one cause on eech line.

		Approximate Interval Between Onset and Death
Immediete Cause (Final disease or condition resulting in death) a.	Sepsis	2 weeks
Due to (or as a consequence of): b.	Dermal ulcer left heel	3 weeks
Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	Atherosclerotic Cardiovascular Disease	years
Due to (or as a consequence of): d.	Hypothyroidism	years

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: osteoarthritis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the lime, dete end place, and due to the cause(s) and menner steted.

29b. Signature and title of certifier: Perfecto C. Valarao M.D.
29c. License number: D16389
29d. Dete signed (Month, Day, Year): August 1, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PERFECTO C. VALARAO, M.D. 1716 HARFORD RD FALLSTON MD 21047

State Registrar

31. Dete filed (Month, Day, Year): AUG 2 - 1999
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25784

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: RJ Elixson

2. Date of Death Month Day Year: August 2, 1999

3. Time of Death: 11:50 am

4a. Facility Name *(If not institution, give street and number)*: 11700 Old Columbia Pike, #2210

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 263-24-2356

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 75 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: February 20, 1924

9. Birthplace *(State or Foreign Country)*: Florida

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 11700 Old Columbia Pike, #2210

10f. Zip Code: 20904

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Machinist

16b. Kind of Business/Industry: Printing Factory

17. Father's Name *(First, Middle, Last)*: Oscar Elixson

18. Mother's Name *(First, Middle, Maiden Surname)*: Ida Phillips

19a. Informant's Name/Relationship *(Type, Print)*: Edward A. Smith (nephew)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 11700 Old Columbia Pike, #2210, Silver Spring, MD 20904

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Chesapeake Crematory

Date: 8/3/99

20c. Location - City or Town, State: Beltsville, Maryland

21. Signature of Funeral Service Licensee: M00956

22. Name and Address of Facility: Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, MD 20910

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. LUNG CANCER — Approximate Interval: MONTHS

Due to (or as a consequence of):

Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Deepak Cuddapah

29c. License number: D005'1863

29d. Date signed *(Month, Day, Year)*: AUGUST 2, 1999.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Deepak Cuddapah, M.D., 3905 National Drive, #220, Burtonsville, Maryland 20866

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 03 1999

32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(B) R.J. Elixson 4

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25785

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOAN EVERLY
2. Date of Death: Month JULY Day 31, Year 1999
3. Time of Death: 2:32 A.M.
4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 215-42-6617
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 55 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan 29, 1944
9. Birthplace (State or Foreign Country): Maryland

Usuel Residence of Decedent

10a. Stete: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 39 E. Fifth Street Apt 1
10f. Zip Code: 21701
10g. Citizen of What Country?: United States
11. Meritel Stelus: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yes, Give Yaar or Datas:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Bleck, White, etc. Specify: white
15. Decedent's Education (Specify only highest grade completed): Elemantery/Secondary (0-12): 11 College (1-4or 5+): -
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Lab Assistant
16b. Kind of Business/Industry: Ft. Detrick
17. Father's Neme (First, Middle, Last): Wilson Albert Everly
18. Mother's Name (First, Middle, Maiden Surneme): Virginia Sirk
19a. Informant's Neme/Reletionship (Type, Print): Virginia Albright / mother
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): Orchard Manor Dr., Boonsboro, MD 21713 Apt 804
20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from Stete 4☐ Donation 5☐ Other (Specify)
20b. Piece of Disposition (Name of cemetery, crematory or other piece): Mt. Olivet Cemetery
Date: 7/31/99
20c. Location - City or Town, Stete: Frederick, Maryland
21. Signature of Funeral Service Licensee: Paul P.B. Mackey
22. Nama end Address of Fecility: Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complicetions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heert feilura. Lisl only ona ceusa on aech lina.

Approximate Interval Between Onsel and Death

Immediete Cause (Finel disaasa or condition resulting in death)
a. Cardiovascular disease
Due to (or es e consequence of):
b. Diabetes Mellitus
Due to (or as a consequence of):
c. COLD
Due lo (or as a consequence of):
d.

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Asthma

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Wes casa refarred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one): Hospitel: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accidenl 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner steted.

29b. Signeture and title of certifier:
29c. License number: D37178
29d. Date signed (Month, Day, Year): 8-3-99

30. Neme and address of person who completed cause of death (Item 23e) (Type, Print): DR. CHRISTOPHER FLEMING 610 NINTH AVE. BRUNSWICK MD. 21716

State Registrar

31. Date filed (Month, Dey, Yeer): AUG 04 1999
32. Registrer's Signeture: Brenda G. Apa

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25786

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Betty L. Elbin

2. Date of Death: Month July Day 29 Year 1999

3. Time of Death: 910 pm

4a. Facility Name (If not institution, give street and number): Pleasant View Nursing Home

4b. City, Town, or Location of Death: Mt Airy

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 219-14-6233

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 5/23/1924

9. Birthplace (State or Foreign Country): Md

Usual Residence of Decedent

10a. State: Md

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 212 Blandford Street

10f. Zip Code: 20850

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): homemaker

16b. Kind of Business/Industry: domestic

17. Father's Name (First, Middle, Last): John Harvey Tressler

18. Mother's Name (First, Middle, Maiden Surname): June Marie Thomas

19a. Informant's Name/Relationship (Type, Print): Robert Louis Elbin (spouse)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): c/o 5007 Randolph Rd., Rockville, Md 20852

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Carroll Cremation Serv. Date: 7-30-99

20c. Location - City or Town, State: Hampstead MD

21. Signature of Funeral Service Licensee: ▶ Paige Haight Herbert

22. Name and Address of Facility: Haight Funeral Home & Chapel P.O. Box 195 Sykesville, Md 21784

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Squamous cell carcinoma of head and neck — six months.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Stroke

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ N B Vellanki

29c. License number: D 30469.

29d. Date signed (Month, Day, Year): July 30th, 1999.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): N B Vellanki, 9055, Chevrolet Drive, #Suite 100, ellicott city, MD 21042.

State Registrar

31. Date filed (Month, Day, Year): AUG 0 3 1999

32. Registrar's Signature: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25787

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James Ennals
2. Date of Death Month Day Year: August 02, 1999
3. Time of Death: 0027
4a. Facility Name (If not institution, give street and number): Dorchester General Hospital
4b. City, Town, or Location of Death: Cambridge
4c. County of Death: Dorchester

Funeral Director

5. Social Security Number: 213-24-0889
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 69 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 06, 1929
9. Birthplace (State or Foreign Country): Maryland

Usual Residance of Decedent

10a. State: MD
10b. County: Dorchester
10c. City, Town or Location: Cambridge
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 503- Hubert Street
10f. Zip Code: 21613
10g. Citizen of What Country?: USA

11. Maritel Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorcad
12. Was Decedent Ever In U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elamantary/Secondary (0-12): 7 | College (1-4or 5+):
16a. Dacedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Upholstery
16b. Kind of Business/Industry: ENTREPRENEUR

17. Father's Name (First, Middle, Last): Aaron thomas Ennals
18. Mother's Name (First, Middle, Maidan Surnama): Rita Ennals

19a. Informant's Name/Ralationship (Type, Print): Donna Patricia McKinney
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 502 Greenwood Ave, Apt. 101 Cambridge, MD. 21613

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Bethel Cemetery
Date: 8/08/99
20c. Location - City or Town, State: Cambridge, MD

21. Signature of Funeral Service Licensee: ▶ Janelle C. Henry
22. Name and Address of Facility: Henry Funeral Home P.A. 510 Washington St. Cambridge, MD. 21613

Physician /Medical Examiner

23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset end Death
Immediate Causa (Final disease or condition resulting in death) a.	Acute pulmonary Edema	10 min
Due to (or as a consequence of): b.	Cardiomyopathy, hypertensive + diabetic.	20 yrs.
Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated avants resulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.	Gangrene	2 mo's

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Atrial flutter, permanent pacertaker, Diabetes, type I. COPD. Peripheral Vascular Disease, Gout.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yas 2 ☒ No

24b. Ware autopsy findings evellable prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was cese raferred to medicel examinar? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Mannar ot Death: 1 ☒ Natural 2 ☐ Accidant 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Panding investigation 6 ☐ Could not be detarmined

28a. Data of Injury (Month, Day Year): N/A
28b. Tima of Injury: N/A M
28c. Injury at Work? 1 ☐ Yes 2 ☒ No
28d. Describe how injury occurred: N/A.
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): N/A
28f. Location (Street and Number or Rural Route Number, City or Town, State): N/A

29a. Certifier (Check only one): 1 ☒ **Certifying Phyaician:** To the best of my knowledga, daath occurred at tha tima, data and place, and due to tha cause(s) and mannar as statad. 2 ☐ **Medical Examinar:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar statad.

29b. Signature end title of certifier: ▶ Allene MD
29c. License number: D11284
29d. Dete signed (Month, Dey, Year): 8.3.99

30. Name and address of parson who complatad ceuse of daath (Item 23a) (Type, Print): Ann Robinson Wilke MD 400 Maryland Ave Cambridge MD 21613

State Registrar

31. Date filed (Month, Day, Year): AUG 05 1999
32. Registrar's Signature: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

99-4425-033
CJ
Merachew L.
Fitigu

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene — 99 25788 Reg. No.

AMEND ITEMS #23 PART I, 27, 28A-F PER MEO G775.8-24-99 WB

Certificate of Death

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Merachew Lucas Fitigu
2. Date of Death: Month July, Day 27, Year 1999
3. Time of Death: 11:49 AM.
4a. Facility Name (If not institution, give street and number): Route 95 nourthbound and Temple Hills Road
4b. City, Town, or Location of Death: Temple Hills
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 552-71-0255
6. Sex: 1 M 2 F
7. Age (In yrs. last birthday): 24 Yrs. — If Under 1 Year: Months, Days — If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): Aug. 28,1974
9. Birthplace (State or Foreign Country): Ethiopia

Usual Residence of Decedent

10a. State: Virginia
10b. County: Alexandria
10c. City, Town or Location: Alexandria
10d. Inside City Limits: 1 Yes 2 No
10e. Street and Number: 5001 Semenary Road
10f. Zip Code: 22311
10g. Citizen of What Country?: United States
11. Marital Status: 1 Never Married 2 Married 3 Widowed 4 Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yas, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yas 2 No Specify:
14. Race - American Indien, Black, White, atc. Specify: Black
15. Decedent's Education (Specify only highest grada completed): Elementary/Secondary (0-12); College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired): Sales Person
16b. Kind of Business/Industry: Computer
17. Fathar's Name (First, Middle, Last): Fitigu Tadesse
18. Mother's Neme (First, Middle, Maiden Surneme): Ruth Seyoum
19a. Informant's Name/Relationship (Type, Print): Ruth Seyoum, mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6372 Wingate Street, Alexandria, Virginia 22312
20a. Mathod of Disposition: 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other placa): Gate of Heaven Cemetery
Date: 8/2/99
20c. Location - City or Town, State: Silver Spring, Maryland
21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: McGuire Funeral Service, Inc. 7400 Georgia Ave. N.W., Washington, D.C.

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Finel disaasa or condition resulting in deeth)
a. TWO GUNSHOT WOUNDS OF THE HEAD AND CHEST
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequenca of):
c.
Dua to (or as a consequence of):
d.

Part II. **Other signifcant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was en autopsy performed? 1 Yes 2 No
24b. Were eutopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was cesa rafarred to medical examiner? 1 Yes 2 No
26. Place of Death (Check only one): Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA; Other: 4 Nursing Home 5 Residence 8 Other (Specify) Scene
27. Manner of Death: 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigetion 6 Could not be determined
28a. Date of Injury (Month, Day Year): 7-27-99
28b. Tima of Injury: 11:45 A M
28c. Injury at Work? 1 Yes 2 No
28d. Describe how injury occurred: SELF-INFLICTED GUNSHOT WOUND AND SHOT BY POLICE
28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify): CAR ON INTERSTATE 95
28f. Location (Street and Number or Rural Route Number, City or Town, State): INTERSTATE 95 & TEMPLE HILLS RD.PG. CO., MD.

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 XX Medical Examiner: On the basis of examinetion and/or investigation, In my opinion, deeth occurred at the time, date and pleca, and due to the cause(s) and manner stated.
29b. Signature and title of cartifier: Stph A Radntz, MD
29c. Licensa number: O.C.M.E.
29d. Date signed (Month, Day, Year): July 28, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): AUG 02 1999
32. Registrar's Signatura: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25789

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Richard Allan Floyd

2. Date of Death: Month July Day 31 Year 1999

3. Time of Death: 7:45 AM

4a Facility Name (If not institution, give street and number): Washington Adventist Hospital

4b. City, Town, or Location of Death: Takoma Park

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 095-32-8155

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 59 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept.15,1939

9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Germantown

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 18707 Sparkling Water Dr., # 101

10f. Zip Code: 20874

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Raca - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): | College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Sales

16b. Kind of Business/Industry: Jewelry

17. Father's Name (First, Middle, Last): Robert Floyd

18. Mother's Name (First, Middle, Maiden Surname): Norma Hoagland

19a. Informant's Name/Retetionship (Type, Print): Camille M. Floyd/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 18707 Sparkling Water Dr., #101,Germantown, MD.20874

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removat from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cemetery

Date: 8/3/1999

20c. Location - City or Town, State: Silver Spring, MD.

21. Signature of Funeral Service Licensee: Michael D Colburn

22. Name and Address of Facility: DeVol Funeral Home, 10 East Deer Park Dr., Gaithersburg, MD. 20877

Physician /Medical Examiner

23a. Part I. Enter the disease, or complicetions that ceused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

		Approximate Interval Between Onset end Death
Immediate Ceuse (Finat disease or condition resulting in death) a.	Congestive Heart Failure	5 years
Due to (or as a consequence of): b.	Myocardial Infarction	15 years
Sequentially list conditions, if any, leading to tmmediate ceuse. Enter Underlying Cause (Diseese or Injury thet initiated events resulting in death) Last — Due to (or as a consequence of): c.	Coronary Artery Disease	15 years
d.		

Part II. **Other significant conditione** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco uss contributs to the causes of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medicel examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Sulcide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of tnjury - At home, ferm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒ **Certifying Physfcfan**: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, end due to the ceuse(s) and manner stated.

29b. Signature end title of certifier: Keith M Lindgren MD

29c. License number: 07966

29d. Date signed (Month, Day, Year): July 31 1999

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Keith M. Lindgren MD 7600 Carroll Ave Takoma Park MD

State Registrar

31. Date filed (Month, Day, Year): AUG 03 1999

32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, pege 2 should be detached for use es the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

12

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25790

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MICHAEL FRANCIS FLYNN, SR.

2. Date of Death — Month: AUGUST Day: 4, Year: 1999

3. Time of Death: 11:30 A.M.

4a. Facility Name *(If not institution, give street and number)*: 1007 BRANTFORD STREET

4b. City, Town, or Location of Death: SILVER SPRING

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 338-12-3165

6. Sex: 1☒M 2☐F

7. Age *(In yrs. last birthday)*: 73 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Date of Birth *(Month, Day, Year)*: NOV. 3, 1925

9. Birthplace *(State or Foreign Country)*: ILLINOIS

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: MONTGOMERY

10c. City, Town or Location: CHICAGO

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 1007 BRANTFORD STREET

10f. Zip Code: 20904

10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*

Elementary/Secondary (0-12): 12

College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: PROCUREMENT MANAGER

16b. Kind of Business/Industry: AIRPORT INDUSTRY

17. Father's Name *(First, Middle, Last)*: MICHAEL FRANCIS FLYNN

18. Mother's Name *(First, Middle, Maiden Surname)*: MARY AGNES WHITE

19a. Informant's Name/Relationship *(Type, Print)*: TIMOTHY J. FLYNN - SON

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 15113 PEACHSTONE DRIVE, SILVER SPRING, MD 20905

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: GATE OF HEAVEN

Date: 8-7-99

20c. Location - City or Town, State: SILVER SPRING, MARYLAND

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVE., SILVER SPRING, MD 20904

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. PAVCREATIC CANCER — 18 MONTHS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ASCITIES

RENAL FAILURE

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Year)*

26b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Mark R Abbruzzese MD

29c. License number: D48226

29d. Date signed *(Month, Day, Year)*: AUGUST 4, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARK R. ABBRUZZESE, M.D., 4910 MASSACHUSETTS AVE., N.W., WASHINGTON, DC 20016

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 06 1999

32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25791

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Myra Frye
2. Date of Death: Month July; Dey 27; Year 1999
3. Time of Death: 9:10pm
4a Facility Name (If not institution, give street end number): Johns Hopkins Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Deeth: Baltimore City

Funeral Director

5. Sociel Security Number: 216-14-1555
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. lest birthday): 78 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Day, Year): Aug. 22, 1920
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1☐ Yes 2☐ No
10e. Street and Number: 8336 Pinecliff Park Road
10f. Zip Code: 21704
10g. Citizen of What Country?: United States

11. Meritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Bleck, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+): –
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Seamstress
16b. Kind of Business/Industry: Sewing Factory

17. Father's Neme (First, Middle, Last): Robert W. Tobery
18. Mother's Name (First, Middle, Maiden Surname): Margaret E. Killion

19a. Informant's Name/Relationship (Type, Print): Rebecca Burgee / daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): Pinecliff Park Road, Frederick, MD 21704

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, crematory or other place): Mt. Olivet Cemetery
Dete: 7/30/99
20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee: ▶ R.P.B. MacKay
22. Name and Address of Fecility: Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediete Cause (Final disease or condition resulting in death)
a. Aortic Stenosis — 5 months
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or es e consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Coronary Artery disease

23b. Did tobacco use contributs to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Sulcide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and piece, and due to the cause(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) end menner stated.

29b. Signeture and title of certifier: ▶ David J. Capunelli MD Surgical Resident
29c. License number: RCS-000
29d. Date signed (Month, Day, Year): July 27, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David J. Capunelli 600 North Wolfe Street Baltimore, Maryland 21287

State Registrar

31. Date filed (Month, Dey, Year): JUL 29 1999
32. Registrar's Signature: ▶ D. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

99-4462-045
crn
Terry Lee Frost

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25792

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
TERRY LEE FROST	July 28, 1999	11:26 A.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Peninsula Regional Medical Center	Salisbury	Wicomico

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
205-44-8684	1☐ M 2☒ F	46 Yrs.			5/27/1953	PA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
DE	Sussex	Felton	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
57 Lake Forest Circle	19943	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced	1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:	1☐ Yes 2☒ No Specify:	Specify: white

15. Decedent's Education (Specify only highest grada completed)		16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired)	16b. Kind of Businass/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	4+	School Teacher	Education

17. Father's Nama (First, Middle, Last)	18. Mother's Nama (First, Middle, Maiden Sumama)
Frank Richard Frost	Patti Jane McNutt

19a. Informant's Name/Ralationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)
Patti J. Frost / mother	1120 West Pittsburg ST., Scottdale, PA 15683

20a. Mathod of Disposition	20b. Place of Disposition (Nama of cematary, crematory or other place)	Data	20c. Location - City or Town, Stata
1☐ Burial 2☒ Cremation 3☐ Removal from Stata 4☐ Donation 5☐ Othar (Specify)	Salisbury Crematory	7/31/99	Salisbury, MD

21. Signature of Funeral Sarvice Licensee	22. Nama and Address of Facility
David H. Thompson M01051	Holloway Funeral Home, P.A. 501 Snow Hill Rd., Salisbury, MD 21804

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disaasa, or complications that caused the death. Do not entar the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failura. List only ona cause on aach line.

		Approximata Interval Batween Onset and Death
Immediata Causa (Final disaasa or condition rasulting in death)	a. Multiple Injuries	
	Dua to (or as a consequence of):	
Sequentially list conditions, if any, laading to immediata cause. Entar Underlying Cause (Disease or injury that initiated events rasulting in death) Last	b.	
	Dua to (or as a consequence of):	
	c.	
	Dua to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Wara autopsy findings available prior to complation of causa of death?
1☒ Yas 2☐ No	1☒ Yes 2☐ No

25. Was casa rafarrad to medical examiner?	26. Place of Death (Check only ona)	
☒ Yas 2☐ No	Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Homa 5☐ Residence 6☐ Othar (Specify)

27. Mannar of Death	28a. Data of Injury (Month, Day Year)	28b. Tima of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐ Natural 2☒ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending Investigation 6☐ Could not be datarmined	7/28/99	0905 M	1☐ Yas 2☒ No	subject driver of vehicle in vehicle not vehicle accident
	28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)			28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)
	roadway			US Route 50 & Route 54 Wicomico County Maryland

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the tima, data and place, and dua to the causa(s) and mannar as stated. 2☒ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, death occurred at tha time, data and place, and dua to the cause(s) and manner stated.

29b. Signatura and title of certifier	29c. Licensa number	29d. Data signed (Month, Day, Year)
Theodore M. Kyprus	O.C.M.E.	July 29, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
THEODORE Myking 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filed (Month, Day, Year)	32. Registrar's Signatura
JUL 30 1999	Geneva G Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25793

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Reva Foreman	07 / 31 / 1999	9:14 pm

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Atlantic General Hospital	Berlin	Worcester

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-18-4789	1☐ M 2☒ F	86 Yrs.			Sept. 26 1912	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Worcester	Berlin	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
10218 Old Ocean City Blvd.	21811	U.S.A

11. Marital Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grede completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)		
5		Domestic	None

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Surneme)
Jessie Purnell	Margie Schoolfield

19a. Informant's Name/Relationship (Type, Print)	19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)
Thelma A. Brown (Sister)	41 Ann Avenue, Dover DE 19904

20a. Method of Disposition	20b. Place of Disposition (Neme of cemetery, cremetory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Calvery U.M.Church Cem.	8/7-99	Ironshire, Md.

21. Signeture of Funeral Service Licensee	22. Name end Address of Facility
▶ Gladys B. Stewart	Stewart Funeral Home 821 West Rd. Salisbury, Md. 21801

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Myocardial Infarctin (Coronary Artry Dx) Due to (or es e consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last	b. Atrial Fibrillatin Dua to (or as e consequence of):	
	c. GI Bleed Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

(1) (b) CVA

(2) Severe Malnutritin / Dehydration

23b. Did tobacco use contributa to the causa of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was cese referred to medical exeminer?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Netural 2☐ Accident 3☐ Sulcide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, dete and place, and due to the ceuse(s) snd manner as stated.
2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
▶ Jeffrey Matzni DO	H0053714	07/31/1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Jeffrey Matzni, DO 9714 Healthway DRIVE BERLIN, MD 21811

State Registrar

31. Date filed (Month, Dey, Year)	32. Registrar's Signature
AUG 03 1999	▶ Donna G Sparks

DHMH 16 Rev 6/95

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

SS# 215-18-4789

Reva Foreman 7/31 21:14

6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25794

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William McKinnley Fisher
2. Date of Death (Month, Day, Year): July 30, 1999
3. Time of Death: 10:30 PM
4a. Facility Name (If not institution, give street and number): Salisbury Center: Genesis ElderCare
4b. City, Town, or Location of Death: Salisbury, MD
4c. County of Death: Wicomico

Funeral Director

5. Social Security Number: 220-26-0994
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 69 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug 25, 1929
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Md
10b. County: Somerset
10c. City, Town or Location: Ft. Annr
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 32593 Perry Hawkins
10f. Zip Code: 21853
10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11th — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Sprayer Mech.
16b. Kind of Business/Industry: Campbell Soup Co

17. Father's Name (First, Middle, Last): Robert Fisher
18. Mother's Name (First, Middle, Maiden Surname): Virginia (unknown)

19a. Informant's Name/Relationship (Type, Print): Elinor M. Fisher wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 32593 Perry Hawkins Rd. Ft. Annr md. 21853

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): St Marks un M Ch. Cem — Date: 8/7/99
20c. Location - City or Town, State: Oakville md.

21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: Brown Smith F/H 917 W Isabella St Salisbury md. 21801

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Multiple Sclerosis, Vegetative State — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Severe Dysphagia, Renal insufficiency
CHF, HTN
Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD
29c. License number: D39813
29d. Date signed (Month, Day, Year): 8/2/99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): M Atkins nurse Health unit Drive, Salis MD 21804

State Registrar

31. Date filed (Month, Day, Year): AUG 03 1999
32. Registrar's Signature: Geneva G Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

4 months

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25795

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: George A. Gailes, Jr.
2. Date of Death: Month July Day 31, Year 1999
3. Time of Death: 12:11A.
4a. Facility Name *(If not institution, give street and number)*: 4905 Iroquois Street
4b. City, Town, or Location of Death: College Park
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 215-20-3301
6. Sex: [X] M [ ] F
7. Age *(In yrs. last birthday)*: 73 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: April 26, 1926
9. Birthplace *(State or Foreign Country)*: Washington, D.C.

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: College Park
10d. Inside City Limits: [X] Yes [ ] No
10e. Street and Number: 4905 Iroquois Street
10f. Zip Code: 20740
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? [X] Yes [ ] No If Yes, Give Year or Dates: 1944-1946
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Piano Technician
16b. Kind of Business/Industry: Self employed

17. Father's Name *(First, Middle, Last)*: George A. Gailes, Sr.
18. Mother's Name *(First, Middle, Maiden Surname)*: Mable Inez Couch

19a. Informant's Name/Relationship *(Type, Print)*: Claire W. Gailes (wife)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: same as #10

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Fort Lincoln Cemetery — Date: Aug. 3, 1999
20c. Location - City or Town, State: Brentwood, Maryland

21. Signature of Funeral Service Licensee: Donald V Borgwardt
22. Name and Address of Facility: Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Metastatic Carcinoma — June 4, 1999

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Essential Hypertension

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Parkinson's Disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: A. Hussain MD
29c. License number: D0013668
29d. Date signed *(Month, Day, Year)*: August 2, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Azher Hussain, M.D. 4917 Edgewood Road College Park, Maryland 20740

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 03 1999
32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25796

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): George Boardman Gardiner, Jr.

2. Date of Death (Month, Day, Year): July 30, 1999

3. Time of Death: 15:50

4e. Facility Name (If not institution, give street and number): Suburban Hospital

4b. City, Town, or Location of Death: Bethesda

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 216-44-9932

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): December 4, 1915

9. Birthplace (State or Foreign Country): Massachusetts

Usual Residance of Decedant

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Bethesda

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 6504 Bannockburn Drive

10f. Zip Code: 20817

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Nevar Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondery (0-12):

College (1-4or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Foreign Service Officer

16b. Kind of Business/Industry: Department of State

17. Father's Neme (First, Middle, Last): George Boardman Gardiner, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Lillian Bond

19e. Informent's Neme/Reletionship (Type, Print): Joan Leaf Gardiner/Wife

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 6504 Bannockburn Drive, Bethesda, Maryland 20817

20e. Method of Disposition: 1 [ ] Buriel 2 [X] Cremetion 3 [ ] Remevel from Stete 4 [ ] Donetion 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other piece): Montgomery Crematorium, Inc.

Date: July 31, 1999

20c. Location - City or Town, Stata: Bethesda, Maryland

21. Signature of Funeral Service Licensee: Michael S Higgins M00846

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home / Bethesda-Chevy Chase, Inc. 7557 Wiscosin Avenue, Bethesda, Maryland 20814-3501

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on eech line.

Approximete Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)

a. MYOCARDIAL INFARCTION — 8 DAYS

Due to (or as a consequence of):

b. CORONARY ARTERIOSCLEROSIS

Sequentially list conditions, if eny, leeding to immediete causa. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Lest

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

PROSTATE CANCER

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Deeth (Check only one)

Hospitel: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Menner of Death: 1 [X] Naturel 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated. 2 [ ] Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner steted.

29b. Signature end title of certifier: Elliot R Goldstein MD

29c. License number: D03581

29d. Dete signed (Month, Day, Year): 8/2/99

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Elliot R. Goldstein, MD 9410 OLD GEORGETOWN ROAD, BETHESDA, MARYLAND 20814

State Registrar

31. Dete filed (Month, Dey, Year): AUG 03 1999

32. Registrar's Signature: G. Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

George Card 12a 7-30-99 1550

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DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25797

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Janet D. Gardner
2. Date of Death (Month, Day, Year): August 4, 1999
3. Time of Death: 1:20 PM
4a. Facility Name (If not institution, give street and number): Genesis ElderCare Layhill Center
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 051-32-2441
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 59 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 18, 1940
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 816 Easley Street, #525
10f. Zip Code: 20910
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Home Health Aide
16b. Kind of Business/Industry: Nursing
17. Father's Name (First, Middle, Last): Edward Oliver
18. Mother's Name (First, Middle, Maiden Surname): Lila Oliver
19a. Informant's Name/Relationship (Type, Print): Michelle Lynne Marsh (daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as 10
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory
Date: 8-6-99
20c. Location - City or Town, State: Beltsville, Maryland
21. Signature of Funeral Service Licensee: ▶ Ellen H. Rapp
22. Name and Address of Facility: Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

(b)

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic Breast Cancer — 1 year
Due to (or as a consequence of):
b. Metastatis to Brain

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

6

29e. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Khalid Shehadeh
29c. License number: D43496
29d. Date signed (Month, Day, Year): August 5, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 8630 Fenton Street Suite 700 Silver Spring MD 20910 Mohammad Khalid, M. D.

State Registrar

31. Date filed (Month, Day, Year): AUG 06 1999
32. Registrar's Signature: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25798

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Helen Hunt Garges
2. Date of Death (Month, Day, Year): August 1, 1999
3. Time of Death: 8:00 AM
4a. Facility Name (If not institution, give street and number): 4601 N. Park Ave. Chevy Chase, MD 20815
4b. City, Town, or Location of Death: Chevy Chase
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 145-38-0219
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 2, 1916
9. Birthplace (State or Foreign Country): Wash., D.C.

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Chevy Chase
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4601 N. Park Ave.
10f. Zip Code: 20815
10g. Citizen of Whet Country?: USA

11. Meritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Personnel
16b. Kind of Business/Industry: US State Dept.

17. Fether's Neme (First, Middle, Last): Raymond Hunt
18. Mother's Neme (First, Middle, Meiden Surneme): Helen Johnson

19a. Informent's Name/Relationship (Type, Print): Susan Garges/Daughter
19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 7804 Glenbrook Rd. Bethesda, MD 20814

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donation 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, crematory or other piece): Arlington Nat. Cemetery
Dete: Aug. 5, 1999
20c. Location - City or Town, Stete: Arl., Virginia

21. Signature of Funerel Service Licensee: James D. Dell
22. Neme end Address of Facility: DeVol Funeral Home 2222 Wisconsin Ave., N.W. Washington, D.C. 20007

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications that ceused the deeth. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heert failure. List only one ceuse on eech line.

Approximate Interval Between Onset end Deeth

Immediate Ceuse (Final disease or condition resulting in death): e. Emphysema — Years

Due to (or es e consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in deeth) Last

b. Due to (or es e consequence of):

c. Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobecco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings aveilable prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physicien:** To the best of my knowledge, death occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the besis of exemination end/or investigetion, in my opinion, death occurred et the time, dete end place, end due to the ceuse(s) end menner steted.

29b. Signature end title of certifier: Robert W. Langevin, M.D.
29c. License number: D2306
29d. Dete signed (Month, Dey, Year): August 2, 1999

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print): Robert W. Langevin, M.D. 5454 Wisconsin Ave. #1125 Chevy Chase, Maryland 20815

State Registrar

31. Date filed (Month, Dey, Year): AUG 03 1999
32. Registrer's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25799

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Helen Barbara Gibbs
2. Date of Death (Month, Day, Year): July 29, 1999
3. Time of Death: 10:45PM
4a. Facility Name (If not institution, give street and number): Gilchrist Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 228-18-4071
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 19, 1914
9. Birthplace (State or Foreign Country): Philippine

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3314 Chiswick Court
10f. Zip Code: 20906
10g. Citizen of What Country?: U.S.A

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - Americen Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Freelance Artist
16b. Kind of Business/Industry: Self-Employed

17. Father's Name (First, Middle, Last): Harry Drake Gibbs
18. Mother's Name (First, Middle, Meiden Surname): Camille L. Hopper

19a. Informant's Name/Relationship (Type, Print): Emma Carroll Diggs-Sister
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 8430 Charles Valley Ct., Apt. D, Towson, MD 21204

20a. Method of Disposition: 1☐ Burial 2☒ Cramation 3☐ Removal from Stata 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremefory or othar piece): National Crematory
Date: 7/31/99
20c. Location - City or Town, State: Falls Church, VA

21. Signature of Funarel Service Licensee: Thomas E Hombaker
22. Name and Address of Facility: Joseph Gawler's Sons INC, 5130 Wisconsin Ave. NW, Washington, DC 20016

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that causad the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. renal cell cancer — 4 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Dua to (or as a consequence of):
d.

Part II. **Other signifIcant conditIons** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of ceusa of deeth? 1☐ Yes 2☐ No

25. Was cese referred to medicel examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 8☒ Other (Specify) Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homlcide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Yaar)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Phyalcian:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: A Anthony Riley. MD
29c. Licansa number: D25205
29d. Date signed (Month, Day, Year): July 30, 1999

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): W.A. Riley GBMC 6701 N. Charles St. Balto. MD 21204

State Registrar

31. Date filed (Month, Day, Year): AUG 02 1999
32. Registrar's Signature: Geneva G. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

BARBARA GIBBS July 29, 1999 2245

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25800

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JOHN ALOYSIUS GILSON, SR.

2. Date of Death (Month, Day, Yaar): Aug. 1, 1999

3. Time of Death: 7:15AM

4a. Facility Neme *(If not institution, giva straat and number)*: Villa Rosa Home

4b. City, Town, or Location of Daath: Mitchellville

4c. County of Death: Prince George's

Funeral Director

5. Social Security Numbar: 579-12-7694

6. Sax: 1☒ M 2☐ F

7. Aga *(In yrs. last birthday)*: 95 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: March 6, 1904

9. Birthplaca *(Stata or Foraign Country)*: DC

Usual Rasidance of Dacedant

10a. Stata: Maryland

10b. County: Montgomery

10c. City, Town or Location: Bethesda

10d. Insida City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 6210 Massachusetts Avenue

10f. Zip Coda: 20816

10g. Citizan of Whet Country?: USA

11. Maritai Status: 1☐ Navar Married 2☐ Married 3☒ Widowad 4☐ Divorced

12. Was Dacadant Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:

13. Was Dacadant of Hispenic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 1☐ Yas 2☒ No *Specify:*

14. Raca - American Indian, Black, Whita, atc. *Specify:* White

15. Dacedant's Education *(Specify only highast grada complatad)*: Elamantary/Sacondary (0-12): 9; Collaga (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa ratired)*: Fire Fighter

16b. Kind of Businass/Industry: Federal Government

17. Fathar's Nama *(First, Middla, Last)*: James A. Gilson

18. Mothar's Nama *(First, Middla, Maidan Surnama)*: Margaret C. Butler

19a. Informant's Name/Ralationship *(Typa, Print)*: Theresa Barlow / Daughter

19b. Mailing Address *(Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 6210 Massachusetts Ave., Bethesda, MD 20816

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Placa of Disposition *(Nama of camatary, cramatory or othar placa)*: Gate of Heaven

Data: Aug 4 1999

20c. Location - City or Town, Stata: Silver Spring, MD

21. Signature of Funaral Sarvica Licansee: ▶ Teaky A. Stover

22. Nama and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such es cardiac or raspiratory errast, shock, or haart feilura. List only one causa on aach lina.

Approximata Intarval Batwaen Onset and Death

Immediata Causa (Final disease or condition rasulting in daath)

a. Arteriosclerotic Cardiovaswlar Disease — 4 years

Dua to (or as a consaquance of):

Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Disaasa or injury that initiated avants rasulting in daath) Last

b.

Dua to (or as a consequance of):

c.

Dua to (or as a consaquanca of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying cause givan in Part I.

Parkinson's Disease

Antemial Hypertension

Renal Insufficiency

23b. **Did tobacco use contribute to the cause of deeth?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performad? 1☐ Yes 2☒ No

24b. Wara autopsy findings availabla prior to compiation of causa of daath? 1☐ Yes 2☐ No

25. Was casa rafarrad to madical examinar? 1☐ Yas 2☒ No

26. Placa of Daath *(Check only ona)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpetient 3☐ DOA; Othar: 4☒ Nursing Homa 5☐ Rasidance 6☐ Other *(Specify)*

27. Mannar of Daath: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not ba datarmined

28a. Data of Injury *(Month, Day Yaar)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. *(Spacify)*

28f. Location *(Streat and Number or Rural Routa Number, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar stated.

29b. Signatura and title of certifiar: ▶ Paul A. DeVore MD

29c. Licansa number: D01852

29d. Data signed *(Month, Day, Yaar)*: August 1, 1999

30. Nama and addrass of person who compiated causa of daath (Item 23a) (Type, Print): PAUL A. DeVORE, MD 4203 Queensbury Rd Hyattsville MD 20781

State Registrar

31. Data filed *(Month, Day, Yaar)*: AUG 03 1999

32. Registrar's Signatura: Geneva G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25801

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ESTHER ELIZABETH GOLDING

2. Data of Death Month / Day / Year: AUGUST 3, 1999

3. Time of Death: 07:25 a.m.

4a. Facility Name *(If not institution, give street and number)*: Calvert Memorial Hospital

4b. City, Town, or Location of Death: Prince Frederick

4c. County of Death: Calvert

Funeral Director

5. Social Security Number: 072-10-8353

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: May 7, 1916

9. Birthplace *(State or Foreign Country)*: Buffalo, NY

Usual Residence of Decedent

10e. State: MD

10b. County: Calvert

10c. City, Town or Location: Lusby

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 125-77 Sage Brush Drive

10f. Zip Code: 20657

10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Clerk

16b. Kind of Business/Industry: Dept. of Agriculture

17. Father's Name *(First, Middle, Last)*: Chester H. Golding, Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Gretchen M. Whittenberger

19a. Informant's Name/Relationship *(Type, Print)*: Gretchen Condon - Niece

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 265 Osborne Hill Road Fishkill, NY 12524

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metropolitan Crematory

Date: 8/3/99

20c. Location - City or Town, State: Alexandria, VA

21. Signature of Funeral Service Licensee: Karen W. Doe

22. Name and Address of Facility: Metropolitan Funeral Service, Inc. 5517 Vine Street Alexandria, VA 22310

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) a. COPD exacerbation — 2 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: CARCINOMA COLON, DEMENTIA, ENCEPHALOPATHY, HYPOPROTENEMIA

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D36909

29d. Date signed *(Month, Day, Year)*: 8/3/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR SCARIA MATHEW, M.D. Lusby, Maryland 20657

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 06 1999

32. Registrar's Signature: Teresa B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 25802

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: PETRA J. GORDON

2. Date of Death Month Day Year: 08.03.1999

3. Time of Death: 16:38

4a. Facility Name *(If not institution, give street and number)*: WASHINGTON ADVENTIST HOSPITAL

4b. City, Town, or Location of Death: TAKOMA PARK

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 216.30.2550

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 65 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 08.10.1933

9. Birthplace *(State or Foreign Country)*: NY

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: PRINCE GEORGES

10c. City, Town or Location: ADELPHI

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2507 MUSKOGEE STREET

10f. Zip Code: 20873

10g. Citizen of What Country?: USA

11. Meritel Stetus: 1☐ Navar Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grada completed)*: Elementery/Secondary (0-12): — College (1-4or 5+): 1

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOMEMAKER

16b. Kind of Business/Industry: OWN HOME

17. Father's Name *(First, Middla, Last)*: HERMAN JACOBS

18. Mother's Name *(First, Middle, Maiden Sumama)*: ADELYN VENEZKY

19e. Informent's Neme/Relationship *(Type, Print)*: FRED J. GORDON/HUSBAND

19b. Mailing Addrass *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2507 MUSKOGEE STREET, ADELPHI, MARYLAND 20873

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other place)*: KING DAVID MEMORIAL GDNS — Data: 8.5.99

20c. Location - City or Town, State: FALLS CHURCH, VIRGINIA

21. Signeture of Funarel Service Licensee:

22. Neme end Address of Fecility: EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

Physician /Medical Examiner

23e. Part1. Enter the diseese, or complicetions thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert failura. List only one cause on eech line.

Approximete Interval Between Onset and Death

Immedieta Causa (Final diseese or condition resulting in death)
a. MYOCARDIAL INFARCTION — 1 HOUR

Dua to (or as a consequence of):

Sequentially list conditions, if any, leeding to immadiete cause. Enter Underlying Cause (Disease or injury thet initiated avants resulting in death) Last
b. ATHERIOSCLERATIC HEART DISEASE — 2 YEARS

Due to (or as e consequence of):

c.

Due fo (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: ESOPHAGEAL STRICTURE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be detarmined

28a. Dete of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At homa, farm, straet, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On tha basis of examination end/or invastigation, in my opinion, daath occurred at the time, data end piece, and due to the cause(s) and menner steted.

29b. Signature and title of certifier: Alan R. Weinstock M.D.

29c. License number: D09748

29d. Data signed *(Month, Day, Year)*: 08.04.1999

30. Neme and address of person who completed cause of daath (Item 23a) (Type, Print): DR. ALAN R. WEINSTOCK, 10310 GEORGIA AVENUE, #750, SILVER SPRING, MARYLAND 20815

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 06 1999

32. Registrer's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 25803

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: IRWIN SELNICK GOTTESMAN

2. Date of Death Month Day Year: 7.29.99

3. Time of Death: 2:04 PM

4a Facility Name *(If not institution, give street and number)*: HEBREW HOME OF GREATER WASHINGTON

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 017.01.0096

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Yeer)*: 10.12.1915

9. Birthplace *(State or Foreign Country)*: MASS.

Usual Residence of Decedent

10a. State: MD

10b. County: MONTGOMERY

10c. City, Town or Location: ROCKVILLE

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 6111 MONTROSE ROAD

10f. Zip Code: 20852

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4 or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: SUPERVISOR

16b. Kind of Business/Industry: FASHION INDUSTRY

17. Father's Name *(First, Middle, Last)*: JOHN GOTTESMAN

18. Mother's Name *(First, Middle, Maiden Surname)*: SOPIA SELNICK

19a. Informant's Name/Relationship *(Type, Print)*: ROBERT GOTTESMAN/SON

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 14916 TALKING ROCK COURT, NORTH POTOMAC, MD 20878

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: JUDEAN MEMORIAL GARDENS

Date: 8.02.99

20c. Location - City or Town, State: OLNEY, MARYLAND

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

Physician /Medical Examiner

10

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. HEPATIC FAILURE — 2 MONTHS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. METASTATIC CARCINOMA OF COLON — MONTHS

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Naturet 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Steven Lipson MD

29c. License number: D05885

29d. Date signed *(Month, Day, Year)*: 07/29/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): STEVEN LIPSON 6121 MONTROSE RD, ROCKVILLE, MD

State Registrar

31. Date filed *(Month, Day, Yeer)*: AUG 03 1999

32. Registrar's Signature: Geneva B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25804

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Dorothy Jenkins Graeff

2. Date of Death: Month August Day 1 Year 1999

3. Time of Death: 6:35pm

4a. Facility Name (If not institution, give street and number): 1003 Decesaris Drive

4b. City, Town, or Location of Death: Lothian

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 577-28-2885

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 5, 1918

9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Lothian

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1003 Decesaris Drive

10f. Zip Code: 20771

10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): Albert C. Hussong

18. Mother's Name (First, Middle, Maiden Surname): Eudora Hazen

19a. Interment's Name/Relationship (Type, Print): Annetta Cook - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 170 Three Rivers Road, Harwood, Maryland 20776

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Hill Cemetery | Date: 8-4-99

20c. Location - City or Town, State: Suitland, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility: Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Congestive Heart Failure	18 months
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Carotid Artery Atherosclerosis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Wayne Bierbaum

29c. License number: D38563

29d. Date signed (Month, Day, Year): August 2, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Wayne Bierbaum, M.D., 134 Owensville Road, West River, Maryland 20776

State Registrar

31. Date filed (Month, Day, Year): AUG 06 1999

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25805

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Elizabeth Alice Gravenstine
2. Date of Death (Month, Day, Year): August 4, 1999
3. Time of Death: 3:05 AM
4a. Facility Name (If not institution, give street and number): Manor Care Silver Spring
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 164-09-7639
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 91 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 19, 1907
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: New Jersey
10b. County: Cape May
10c. City, Town or Location: Villas
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 204 West Hudson Avenue
10f. Zip Code: 08251
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): John Thomas Conroy
18. Mother's Name (First, Middle, Maiden Surname): Olga Roland

19a. Informant's Name/Reletionship (Type, Print): Charles G. Gravenstine (son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 901 Midland Road, Silver Spring, MD 20904

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other piece): Ivy Hill Cemetery
Date: 8-9-99
20c. Location - City or Town, Stete: Philadelphia, Pennsylvania

21. Signature of Funerel Service Licensee: ▶ Eileen H. Rapp
22. Name end Address of Feciility: Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on eech line.

Approximete Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)
a. Lung Cancer — Approximate Interval: Days
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or es e consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner steted.

29b. Signature and title of certifier: ▶ Jenny Y Moy MD
29c. License number: D43260
29d. Date signed (Month, Day, Year): August 4, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jenny Y. Moy, M. D., 13952 Baltimore Avenue, Laurel, MD 20707

State Registrar

31. Date filed (Month, Day, Year): AUG 05 1999
32. Registrar's Signature: ▶ Denise G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25806

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LOUIS GREENBERG
2. Date of Death (Month, Day, Year): AUGUST 4, 1999
3. Time of Death: 12:15 PM
4a. Facility Name (If not institution, give street and number): HEBREW HOME OF GREATER WASHINGTON
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 040-03-6083
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): AUG. 17, 1911
9. Birthplace (State or Foreign Country): CONNECTICUT

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: MONTGOMERY
10c. City, Town or Location: ROCKVILLE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 6105 MONTROSE ROAD
10f. Zip Code: 20852
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1 [ ] Navar Marriad 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yaar or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): BUSINESS MANAGER
16b. Kind of Business/Industry: OLMER BROS. BAKERY

17. Father's Name (First, Middle, Last): JACOB I. GREENBERG
18. Mother's Name (First, Middle, Maiden Surname): LENA (UNAVAILABLE)

19a. Informant's Name/Relationship (Type, Print): HARVEY GREENBERG (SON)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5837 BERKSHIRE COURT-ALEXANDRIA, VIRGINIA 22303

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [X] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): BETH ISRAEL CEMETERY
Date: 8/6/99
20c. Location - City or Town, State: NEW HAVEN, CONNCETICUT

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE-ROCKVILLE, MARYLAND 20852

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or hiart tailure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Myocardial infarction	Immediate
Due to (or as a consequence of): b.	Arteriosclerotic heart disease	Years
Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contributa to the causa of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performad? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to compietion of ceuse of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, deeth occurred et the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signeture and title of certifier: [signature] MD
29c. License number: D23958
29d. Date signed (Month, Dey, Year): 8/4/99

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Burt I. Feldman, MD, 6105 Montrose Rd, Rockville MD 20852

State Registrar

31. Data filed (Month, Dey, Year): AUG 06 1999
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25807

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CHARLES GRABILL
2. Date of Death: Month 08 Dey 02 Year 99
3. Time of Death: 2200
4a. Facility Name (If not institution, give street and number): UNIVERSITY OF MARYLAND HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death: BALTO CITY

Funeral Director

5. Social Security Number: 214-10-4556
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 21, 1918
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 750 Carroll Parkway
10f. Zip Code: 21701
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1944-45
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): owner/operator
16b. Kind of Business/Industry: plumbing, heating, air conditioning

17. Father's Name (First, Middle, Last): Bayard C. Grabill
18. Mother's Name (First, Middle, Maiden Surname): Cora Weller

19a. Informant's Name/Relationship (Type, Print): Viva H. Grabill/ wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 750 Carroll Parkway Frederick, MD 21701

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Carroll Cremation, Inc.
Date: 8/3/99
20c. Location - City or Town, State: Hampstead, MD

21. Signature of Funeral Service Licensee: ▶ Catharine O. VanBlen
22. Name and Address of Facility: Hartzler Funeral Home 11802 Liberty Rd. Libertytown, MD 21762

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. RESPIRATORY ARREST
Due to (or as a consequence of):
b. STROKE
Due to (or as a consequence of):
c. SEPSIS
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Lisa Nipkow MD
29c. License number: P12452
29d. Date signed (Month, Day, Year): 8/2/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): LISA NIPKOW 22 S. GREENE ST BALTO, MD

State Registrar

31. Date filed (Month, Day, Year): AUG 04 1999
32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25808

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Raymond W Godman
2. Date of Death (Month, Day, Year): July 28, 1999
3. Time of Death: 7:00 pm
4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 214-14-0124
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Mar. 26, 1921
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 11016 Horseshoe Dr.
10f. Zip Code: 21701
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1943-46
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): press brake operator
16b. Kind of Business/Industry: stainless steel mfg.

17. Father's Name (First, Middle, Last): Arthur Godman
18. Mother's Name (First, Middle, Maiden Surname): Myrle Brooks

19a. Informant's Name/Relationship (Type, Print): Dorothy K. Godman/ wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11016 Horseshoe Dr. Frederick, MD 21701

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Rocky Gap Veterans Cem. | Date: 8/2/99
20c. Location - City or Town, State: Cumberland, MD

21. Signature of Funeral Service Licensee: Catharine D. Hartzler
22. Name and Address of Facility: Hartzler Funeral Home 11802 Liberty Rd. Libertytown, MD 21762

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Congestive Heart Failure	6 months
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Renal Insufficiency	1 year
Due to (or as a consequence of):		
	c. COPD	2 years
Due to (or as a consequence of):		
	d. Aortic insufficiency	1 year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Rheumatoid Arthritis
Esophagitis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: James P. Amerena MD
29c. License number: D36421
29d. Date signed (Month, Day, Year): 7/29/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): James P. Amerena MD 110 Baughmans Lane Frederick, Md. 21702

State Registrar

31. Date filed (Month, Day, Year): AUG 0 2 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25809

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Geraldine Heiston

2. Date of Death: Month 07 Day 29 Year 99

3. Time of Death: 9:29A

4a. Facility Name (If not institution, give street and number): Noble House 2327 N. Charles St

4b. City, Town, or Location of Death: Baltimore MD 21218

4c. County of Death: Balt. City

Funeral Director

5. Social Security Number: 223-34-9359

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 69 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): September 16, 1929

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: None

10c. City, Town or Location: Baltimore

10d. Inside City Limits: ☒ 1 Yes 2☐ No

10e. Street and Number: 1232 North Calvert Street

10f. Zip Code: 21202

10g. Citizen of What Country? United States of America

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Russell W. Neighbor

18. Mother's Name (First, Middle, Maiden Surname): Louise Lovell

19a. Informant's Name/Relationship (Type, Print): Albert Heiston/ Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21202: 1232 North Calvert Street, Baltimore, Maryland

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Beahm's Chapel Cemetery

Date: August 1, 1999

20c. Location - City or Town, State: Luray, Virginia

21. Signature of Funeral Service Licensee #M00690: Howard A Carson

22. Name and Address of Facility: The Bradley Funeral Home, 187 East Main Street, Luray, Virginia 22835

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Adenocarcinoma of Pancreas and Duodenum

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Chronic renal failure, Diabetes Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number. City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: D Seely II

29c. License number: D17537

29d. Date signed (Month, Day, Year): 7-29-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DARSHAN S. SALUJA MD 1600 W. MOUNT Royal Ave, Balto 21217

State Registrar

31. Date filed (Month, Day, Year): AUG 03 1999

32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25810

Certificate of Death Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ann L. Hayes
2. Date of Death: Month July Day 31, Year 1999
3. Time of Death: 1:17 pm
4a. Facility Name (If not institution, give street and number): Shady Grove Adventist Hospital
4b. City, Town, or Location of Death: Rockville, MD
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 145-22-2205
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 93 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): August 23,1905
9. Birthplace (State or Foreign Country): New Jersey

Usual Residence of Decedent

10a. State: Md.
10b. County: Montgomery
10c. City, Town or Location: Gaithersburg
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 401 Russell Ave #103
10f. Zip Code: 20877
10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Executive Secretary
16b. Kind of Business/Industry: Insurance

17. Father's Name (First, Middle, Last): Samuel Kunich
18. Mother's Name (First, Middle, Maiden Surname): Susan Geduldig

19a. Informant's Name/Relationship (Type, Print): Richard S. Hayes (son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1316 MacBeth Street McLean, Va. 22102

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory
Date: Aug 2, 1999
20c. Location - City or Town, State: Alexandria, Va.

21. Signature of Funeral Service Licensee: ▶ Curtis E. Day
22. Name and Address of Facility: DeVol Funeral Home 10 East Deer Park Dr. Gaithersburg, Md. 20877

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Diverticular hemorrhage	4days
Due to (or as a consequence of): b.	cerebral hypotension	4days
Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	hemorrhagic shock	1day.
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: History TIA/CVA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ [signature] MD
29c. License number: D24994
29d. Date signed (Month, Day, Year): August 1, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARK BIRNS, MD 9711 MEDICAL CENTER DRIVE ROCKVILLE, MD

State Registrar

31. Date filed (Month, Day, Year): AUG 05 1999
32. Registrar's Signature: ▶ [signature] G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25811

Certificate of Death Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Zita M. Hoelke
2. Data of Death Month Day Year: July 29, 1999
3. Time of Death: 1:20 PM
4a. Facility Name (If not institution, give street and number): 12600 Lamp Post Lane
4b. City, Town, or Location of Death: Potomac
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 498-22-4146
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 75 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): August 21, 1923
9. Birthplace (State or Foreign Country): Missouri

Usual Residence of Decedent

10a. State: Florida
10b. County: Volusia
10c. City, Town or Location: DeLeon Springs
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 5615 Keller Avenue
10f. Zip Code: 32130
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): - ; College (1-4or 5+): 1
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Frederick Pagel
18. Mother's Name (First, Middle, Maiden Surname): Zita Harvey

19a. Informant's Name/Relationship (Type, Print): Patricia J. Kelly/ Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12600 Lamp Post Lane, Potomac, Maryland 20854

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Montgomery Crematorium, Inc. Date: August 2, 1999
20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: [signature] M00689
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Pancreatic Cancer	6 months
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.		
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Daughter's residence

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] David Perry MD
29c. License number: D18561
29d. Date signed (Month, Day, Year): July 29, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David J. Perry, M.D. 110 Irving Street, NW, Washington, DC 20010-2975

State Registrar

31. Date filed (Month, Day, Year): AUG 05 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25812

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CHARLES HOFFMAN
2. Date of Death (Month, Day, Year): AUGUST 4, 1999
3. Time of Death: 5:00 AM
4a. Facility Name (If not institution, give street and number): JEWISH FOUNDATION GROUP HOME
4b. City, Town, or Location of Death: SILVER SPRING
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 212-86-3053
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 56 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JUNE 14, 1943
9. Birthplace (State or Foreign Country): WASHINGTON, DC

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: MONTGOMERY
10c. City, Town or Location: SILVER SPRING
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 912 DEVERE DRIVE
10f. Zip Code: 20903
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CLERICAL
16b. Kind of Business/Industry: C.H.I.

17. Father's Name (First, Middle, Last): EARL A. HOFFMAN
18. Mother's Name (First, Middle, Maiden Surname): BARBARA EPSTEIN

19a. Informant's Name/Relationship (Type, Print): EARL A. HOFFMAN (FATHER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10201 GROSVENOR PLACE #421-ROCKVILLE, MD. 20852

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MT. COMFORT CREMATORY
Date: 8/5/99
20c. Location - City or Town, State: ALEXANDRIA, VIRGINIA

21. Signeture of Funeral Service Licensee: ▶ Donald G. Stottlemyer
22. Name and Address of Facility: DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE-ROCKVILLE, MD. 20852

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ACUTE MYOCARDIAL INFARCTION — INSTANT

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
MULTIPLE CONGENITAL ABNORMALTIES
GASTROESOPHAGEAL REFLUX

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) GROUP HOME

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Martin C Shargel D
29c. License number: D08944
29d. Date signed (Month, Day, Year): AUGUST 4, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARTIN C. SHARGEL, MD - 3720 FARRAGUT AVENUE - KENSINGTON, MARYLAND 20895

State Registrar

31. Date filed (Month, Day, Year): AUG 06 1999
32. Registrar's Signature: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25813

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Bertha K. Holmes

2. Date of Death Month Day Year: August 3, 1999

3. Time of Death: 6:15 AM

4a. Facility Name *(If not institution, give street and number)*: Brooke Grove Rehabilitation & Nursing Center

4b. City, Town, or Location of Death: Sandy Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 144-03-6162

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: September 18, 1915

9. Birthplace *(State or Foreign Country)*: New Jersey

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1523 Foster Road

10f. Zip Code: 20905

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Dates:

13. Was Dacedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 1☐ Yes 2☒ No *Specify:*

14. Raca - Amarican Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highast grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Licensed Practical Nurse

16b. Kind of Business/Industry: Nursing

17. Father's Name *(First, Middle, Last)*: Austin Wintermute

18. Mother's Name *(First, Middle, Maiden Sumama)*: Lillie Mae Shelley

19a. Informent's Name/Relationship *(Type, Print)*: Harold V. Holmes (husband)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1523 Foster Road, Silver Spring, Maryland 20905

20a. Method of Disposition: 1☐ Burial 2☒ Cramation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other placa)*: Chesapeake Crematory

Date: 8/4/99

20c. Location - City or Town, State: Beltsville, Maryland

21. Signature of Funeral Service Licapsee: ▶ Eileen H. Rapp

22. Name and Addrass of Facility: Rapp Funeral Services, P. A.
933 Gist Avenue, Silver Spring, MD 20910

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Coronary Artery Disease — years

Due to (or es e consequenca of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disaase or Injury that initiated events resulting in deeth) Last

b. Due to (or as a consequenca of):

c. Dua to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying cause given in Part I.

Senile Dementia

Pneumonia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Sulcide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requiras that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by tha funeral director, page 2 should be detached for use as the burial-transit

29a. Cartifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ MD.

29c. License number: D 38457

29d. Date signed *(Month, Day, Year)*: August 3, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Nakul Goyal, M. D., 3801 International Drive, #211, Silver Spring, MD 20906

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 04 1999

32. Registrar's Signature: ▶ Geneva B. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25814

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Carmen Lopez Horton

2. Date of Death (Month, Day, Year): July 31, 1999

3. Time of Death: 10:54 AM

4a. Facility Name (If not institution, give street and number): Collingswood Nursing Center

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-34-7313

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 91 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 5, 1908

9. Birthplace (State or Foreign Country): Philippine Islands

Usual Residence of Decedent

10e. Stete: Maryland

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 299 Hurley Avenue

10f. Zip Code: 20850

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No. If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.): 1☒ Yes 2☐ No Specify: Filipino

14. Race - Americen Indian, Black, White, etc. Specify: Filipino

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): | College (1-4or 5+): 4

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary to the Ambassador

16b. Kind of Business/Industry: Embassy of Nicaragua

17. Father's Name (First, Middle, Last): Lutgardo L. Lopez

18. Mother's Name (First, Middle, Meiden Sumeme): Carmen Hernandez

19e. Informant's Neme/Relationship (Type, Print): Lutgardo F. Lopez (nephew)

19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Steje, Zip Code): B17,L24, Ebony Street, PH IV, Multinational Village, Paranaque City, Philippines

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Chesapeake Crematory

Date: 8-3-99

20c. Location - City or Town, State: Beltsville, Maryland

21. Signature of Funerel Servica Licensee: ▶ Ellen H. Rapp

22. Name and Address of Facility: Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910

To Be Completed by Funeral Director

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximete Intervel Between Onset end Deeth

Immediete Cause (Finel disease or condition resulting in death)

a. Respiratory Failure — minutes

Due to (or as a consequence of):

Sequentielly list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last

b. Lung Carcinoma — months

Due to (or es e consequence of):

c.

Due to (or as a consequenca of):

d.

Part II. **Other significant conditione** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco uee contribute to the cause of death?** 1☐ **Yee** 2☐ **No** 3☐ **Probably** 4☐ **Unknown**

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of ceuse of deeth? 1☐ Yes 2☒ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Phyeician:** To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature end title of certifier: ▶ S. Abulfarag

29c. License number: D 31391

29d. Dete signed (Month, Day, Year): August 2, 1999

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print): Suhair H. Abulfarag, M. D., 481 North Fredeick Avenue, #230, Gaithersburg, MD 20879

State Registrar

31. Dete filed (Month, Day, Year): AUG 03 1999

32. Registrar's Signature: ▶ Irene G. Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(D) 4

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25815

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Edgar Brittain HARROD JR
2. Date of Death: Month August Day 04, Year 1999
3. Time of Death: 9:05 pm
4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 216-07-2490
6. Sex: 1☐ M 2☐ F — X
7. Age (In yrs. last birthday): 79 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 26, 1920
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 6650 Springhill Drive
10f. Zip Code: 21702
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No — If Yes, Give Year or Dates: 1944-1946
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☐ No X — Specify:
14. Race - American Indian, Black, White, etc. — Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Engineer
16b. Kind of Business/Industry: Government

17. Father's Name (First, Middle, Last): Edgar Brittain Harrod Sr.
18. Mother's Name (First, Middle, Maiden Surname): Anna Rogers

19a. Informant's Name/Relationship (Type, Print): Mrs. Carol A. Zimmerman, Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6650 Springhill Dr., Frederick, Md. 21702

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Woodlawn Cemetery, Aug.
Date: 7, 1999
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Richard E. Hay M00255
22. Name and Address of Facility: Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick,Md. 21701

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Arteriosclerotic Cardiovascular Disease — Years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☒ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D35164
29d. Date signed (Month, Day, Year): August 05, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Andrew Zarick, Jr, M.D., 1080 West Patrick Street, Frederick, Maryland 21703

State Registrar

31. Date filed (Month, Day, Year): AUG 06 1999
32. Registrar's Signature: Geneva G. Hanks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25816

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: WALTER JAMES HERFORD
2. Data of Death — Month: JULY Day: 31 Year: 1999
3. Time of Death: 1906
4a. Facility Name *(If not institution, give street and number)*: SHADY GROVE ADVENTIST HOSPITAL
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 162-14-6229
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 77 Yrs.
If Under 1 Year — Months: Days:
If Under 24 Hrs. — Hours: Min.:
8. Data of Birth *(Month, Day, Year)*: Jan. 21, 1922
9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Gaithersburg
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 12 Whetstone Drive Apt. 5
10f. Zip Code: 20877
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: W.W.II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): College (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Cartographer
16b. Kind of Business/Industry: Defense Maping Agengy

17. Father's Name *(First, Middle, Last)*: Walter Frank Herford
18. Mother's Name *(First, Middle, Maiden Surname)*: Nora Ethel Halderman

19a. Informant's Name/Relationship *(Type, Print)*: Kathryn Moran/ Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7146 Boyers Mill Road, New Market, Maryland 21774

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Flower Hill Cemetery
Date: 8/6
20c. Location - City or Town, State: Gaithersburg, Maryland

21. Signature of Funeral Service Licensee: Isabel D. Wynn
22. Name and Address of Facility: Olin L. Molesworth P. A. Funeral Home 26401 Ridge Road, Damascus, Maryland 20872

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE — YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD (ONE)
29c. Licensa number: 015236
29d. Data signed *(Month, Day, Year)*: JULY 31, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CARL I. MARGOLIS M.D. 11125 ROCKVILLE PIKE, ROCKVILLE, MD 20852

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 04 1999
32. Registrar's Signature: B. Sparks

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25817

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death
Jennifer	Harris	July 24, 1999	8:09 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Salisbury Center: Genesis ElderCare	Salisbury, MD	Wicomico

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-92-6769	1☐ M 2☒ F	24 Yrs.			SEPT. 7, 1974	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	WICOMICO	SALISBURY	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
31586 LARGO TERRACE	21804	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	4	SALESPERSON	SEARS

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
DONALD L. HARRIS	BARBARA A. MURPHY

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
DONALD L. HARRIS - FATHER	31586 LARGO TERRACE SALISBURY, MD 21804

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	PARSONS CEMETERY	7/28/99	SALISBURY, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ B. Kent Phillips, CFSP	BOUNDS FUNERAL HOME, INC. 705 E. MAIN ST. SALISBURY, MD 21804

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. GLIOBLASTOMA MULTIFORME	1 YEAR
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Thomas Atkins	D39813	7/26/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Thomas Atkins 1104 Wallenwood Drive, Salisbury MD 21804

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 28 1999	▶ Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 25818

Certificate of Death

Reg. No.

Harold H. Hingley SS# 560-32-3639
Baltimore, Maryland 21215-0020

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Harold H. Hingley, Jr.	8 / 1 / 99	1030 A

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
PENINSULA REGIONAL MEDICAL CENTER	SALISBURY	WICOMICO

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
560-32-3639	1☒M 2☐F	68 Yrs.			Nov. 10, 1930	California

Usual Residence of Decedent

10e. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Wicomico	Salisbury	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1113 Middleneck Drive	21804	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates: 48-56	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	4	Systems Analyst	ElectricalSystems Analyst

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Harold H. Hingley, Sr.	Golda Bevins

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Patricia Ann Brown (Wife)	1113 Middleneck Drive Salisbury, Md. 21804

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Resurrection Cem.	8-4-99	Ben Salem, PA

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Holly Short-Hannigan	Short Funeral Home 13 E. Grove St. Delmar, DE 19940

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. SEPSIS - RENAL FAILURE

Due to (or as a consequence of):
b. INTESTINAL ISCHEMIA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. ATHEROSCLEROTIC VASCULAR DISEASE

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒**Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Nicholas L. Ogburn MD.	D34593	8/1/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Nicholas Ogburn - 201 Pine Bluff Rd. Suite 25, Salisbury Md 21801

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
AUG 02 1999	▶ Donna G Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

20th IVA

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25819

Amend #8 WCHD 8/4/1999 cle

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Estella Birckhead Horsey

2. Date of Death: Month July Day 30 Year 1999

3. Time of Death: 7;15 AM

4a. Facility Name (If not institution, give street and number): 4924 Lockard Drive

4b. City, Town, or Location of Death: Owings Mills

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 218-20-8953

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 92 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb. 4 1907 JANUARY 4,1907

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Owings Mills

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 4924 Lockard Drive

10f. Zip Code: 21117

10g. Citizen of What Country? U.S.A

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondery (0-12):

College (1-4or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher

16b. Kind of Business/Industry: None

17. Father's Name (First, Middle, Last): John Wesley Birckhead

18. Mother's Name (First, Middle, Maiden Surname): Addie Ennis

19a. Informant's Name/Relationship (Type, Print): Jan Goslee (Niece)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4924 Lockard Dr.Owings Mills,Md.21117

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Springhill Mem.Garden

Date: 8/4/99

20c. Location - City or Town, State: Hebron,Md.

21. Signature of Funeral Service Licensee: ▶ Gladys B. Stewart

22. Name and Address of Facility: Stewart Funeral Home 821 West Rd.Salisbury,Md.21801

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cerebrovascular Accident — 7 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Sharon J. McCormack MD

29c. License number: D38762

29d. Date signed (Month, Day, Year): 8/3/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Sharon J. McCormack MD 5411 Old Frederick Rd. Baltimore, Md. 21229

State Registrar

31. Date filed (Month, Day, Year): AUG 03 1999

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25820

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LOUISE K. HILL

2. Date of Death: Month AUGUST Day 3 Year 1999

3. Time of Death: 8:10 AM

4a. Facility Name (If not institution, give street and number): Glasgow Nursing Home

4b. City, Town, or Location of Death: Cambridge

4c. County of Death: Dorchester

Funeral Director

5. Social Security Number: 220-26-1507

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 95 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 6, 1904

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Dorchester

10c. City, Town or Location: Cambridge

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 852 Hills Point Rd.

10f. Zip Code: 21613

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 4

College (1-4 or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Seamstress

16b. Kind of Business/Industry: Manufacturing

17. Father's Name (First, Middle, Last): Martin Ludwig Keplinger

18. Mother's Name (First, Middle, Maiden Surname): Magdalena Meixner

19a. Informant's Name/Relationship (Type, Print): Mrs. Barbara Elzey/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 852 Hills Point Rd., Cambridge, MD 21613

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Greenlawn Cemetery

Date: 8-6-99

20c. Location - City or Town, State: Cambridge, MD

21. Signature of Funeral Service Licensee: Colleen Curran-Bromwell

22. Name and Address of Facility: Curran-Bromwell Funeral Home, P.A. 308 High St., Cambridge, MD 21613

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Ame

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDIAL INFARCTION — 10 minutes

Due to (or as a consequence of):

b. ATHEROSCLEROSIS — 40 YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. HYPERTENSION — 40 YEARS

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Michael A. Moskowicz MD

29c. License number: D-16609

29d. Date signed (Month, Day, Year): August 3, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MICHAEL A. MOSKOWICZ MD. 503 BYRN ST. CAMBRIDGE MD. 21613

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): AUG 05 1999

32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25821

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BERTHA EPLURIBUS C. HULL

2. Date of Death: Month June, Day 21, Year 1999

3. Time of Death: 0609

4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 219-14-3118

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 87 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): FEB. 23, 1912

9. Birthplace (State or Foreign Country): MARDELA SPRINGS

Usuet Residence of Decedent

10a. State: MD.

10b. County: WICOMICO

10c. City, Town or Location: PARSONSBURG

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 7520 PARSONSBURG ROAD,

10f. Zip Code: 21849

10g. Citizen of Whet Country?: USA

11. Maritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 1☐ Yes 2☒ No Specify:

14. Race - Americen Indien, Bleck, White, etc. Specify: AFRO-AMERICAN

15. Decedent's Educetion (Specify only highest grede completed)

Elementery/Secondery (0-12): 6th

College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): DOMESTIC

16b. Kind of Business/Industry: HOUSEKEEPER

17. Father's Neme (First, Middle, Last): JOHN R. COULBOURN

18. Mother's Neme (First, Middle, Meiden Surneme): ELIZABETH HORSEY

19a. Informent's Neme/Relationship (Type, Print): DIANE SNEAD

19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code): ADDRESS SAME AS ABOVE

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): SPRINGHILL MEMORY GARD.

Dete: 6-26

20c. Location - City or Town, Stete: HEBRON, MD. 21830

21. Signature of Funeral Service Licensee: Loretta B. Jolley

22. Neme end Address of Feciity: JOLLEY MEMORIAL CHAPEL 1213 JERSEY ROAD, SALISBURY, MD. 21801

Physician /Medical Examiner

23a. Part I. Enter the diseese, or compiicetions thet caused the deeth. Do not enter the mode of dying, such es cerdiec or respiretory arrest, shock, or heert feiiure. List only one cause on eech line.

Approximete Interval Between Onset and Deeth

Immediate Cause (Finel diseese or condition resulting in deeth)

e. Aspiration pneumonia — 2 days

Due to (or es e consequence of):

Sequentiellу list conditions, if any, leeding to immediete ceuse. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest

b. CVA

Due to (or es e consequence of):

c. Atrial Fibrillation

Due to (or es e consequence of):

d.

Part II. **Other significant conditтone** contributing to death but not resulting in the underlying ceuse given in Part I.

Rheumatoid, Diabetus

Non-Insulin dependant diabetes mellitus

23b. Dtd tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes an eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings aveilable prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Wes cese referred to medicel exeminer? 1☐ Yes 2☒ No

26. Piece of Deeth (Check only one): Hospitel: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted.
2☐ **Medicet Exeminer:** On the basis of exeminetion end/or investigetion, in my opinion, death occurred et the time, dete end piece, end due to the cause(s) end menner steted.

29b. Signeture end title of certifier:

29c. License number: D26612

29d. Dete signed (Month, Day, Year): 6.21.99

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Michael Crouch MD, 105 Pine Bluff Rd, Suite 2, Salisbury, MD 21801

State Registrar

31. Dete filed (Month, Day, Year): AUG 11 1999

32. Registrer's Signeture: Geneva G Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25822

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Lillian M. Jackson
2. Date of Death (Month, Day, Year): July 30, 1999
3. Time of Death: 8:25 PM

4a. Facility Name *(If not institution, give street and number)*: Montgomery General Hospital
4b. City, Town, or Location of Death: Olney
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 236-18-5699
6. Sex: 1☐ M 2☒ F XX
7. Age *(In yrs. last birthday)*: 87 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: June 27, 1912
9. Birthplace *(State or Foreign Country)*: Buckhannon, WV

Usual Residence of Decedent

10a. State: VA
10b. County: Spotsylvania
10c. City, Town or Location: Spotsylvania
10d. Inside City Limits: 1☒ Yes X 2☐ No
10e. Street and Number: 13311 W. Catharpin Road
10f. Zip Code: 22553
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed XX 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No X — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No X — *Specify:*
14. Race - American Indian, Black, White, etc. — *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Ira Waugaman
18. Mother's Name *(First, Middle, Maiden Surname)*: Redella Grimm

19a. Informant's Name/Relationship *(Type, Print)*: Larry Jackson - Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: P.O. Box 915 Washington Grove, MD 20880

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Sand Run Baptist Church Cemetery
Date: 8/4/99
20c. Location - City or Town, State: Buckhannon, WV

21. Signature of Funeral Service Licensee: Karen W. Dove
22. Name and Address of Facility: Metropolitan Funeral Service, Inc. 5517 Vine St. Alexandria, VA 22310

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Carcinoma Colon
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. bleeding
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Michael D. Sulkin MD
29c. License number: 14545
29d. Date signed *(Month, Day, Year)*: 8/1/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MICHAEL D. SULKIN MD 9715 Medical Center Dr Rockville, Md.

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 04 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25823

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BERTHA E. JAMES
2. Date of Death (Month, Day, Year): July 31 1999
3. Time of Death: 12:40PM
4a. Facility Name (If not institution, give street and number): HOWARD COUNTY GENERAL HOSP
4b. City, Town, or Location of Death: COLUMBIA
4c. County of Death: HOWARD

Funeral Director

5. Social Security Number: 578-12-3499
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 91 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 12, 1907
9. Birthplace (State or Foreign Country): New Jersey

Usual Residence of Decedent

10a. State: Maryland
10b. County: Howard
10c. City, Town or Location: Columbia
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 5675 Harpers Farm Road
10f. Zip Code: 21044
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, apecify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Black, White, etc. Specify: Negro

15. Decedent'a Education (Specify only highest grade completed): Elementery/Secondery (0-12): 10 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife
16b. Kind of Business/Industry: Home

17. Fether's Neme (First, Middle, Last): Charles Brown
18. Mother'a Name (First, Middle, Maiden Surname): Martha Boyd

19a. Informant's Neme/Relationship (Type, Print): Lawrence E. James, Jr. / Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1508 Erskine St., Takoma Park, MD 20912

20e. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory
Date: 8/2/99
20c. Location - City or Town, State: Beltsville, Maryland

21. Signature of Funerel Service Licensee: Lynne T McGuire
22. Name and Address of Facility: McGuire Funeral Service, Inc. 7400 Georgia Ave. N.W., Washington, D.C. 20012

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List *only one* cause on eech line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Respiratory failure	days
Due to (or as a consequence of): b.	Pneumonia	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Congestive heart failure, azotemia, chronic obstructive pulmonary disease

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings eveilable prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date and place, end due to the ceuse(s) and manner steted.

29b. Signature and title of certifier: MD, FCCP
29c. License number: D36845
29d. Date signed (Month, Day, Year): July 31, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MAI-CHI NGUYEN, MD, FCCP 5999 Harpers Farm Rd, # W215, COLUMBIA, MD 21044

State Registrar

31. Date filed (Month, Day, Year): AUG 03 1999
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25824

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
JESSE	FRANKLIN	JOHNSON	July 25, 1999	2:30 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
8076 Cedar Court	Hebron	Wicomico

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-16-6616	1☒ M 2☐ F	82 Yrs.			March 22, 1917	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Wicomico	Hebron	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
8076 Cedar Court	21830	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8	-	Truck Driver	Trucking

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Samuel Johnson	Maggie Hickman

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Katherine V. Johnson/Wife	8076 Cedar Court, Hebron, MD 21830

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Springhill Memory Gardens	7/28/99	Hebron, MD

21. Signature of Funeral Service Licensee: Daniel A. Thompson M01051

22. Name and Address of Facility: Holloway Funeral Home Professional Association, 501 Snow Hill Rd., Salisbury, MD 21804

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Gall Bladder Carcinoma	1½ mths
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 8☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Ronald P. Travitz MD	D36576	7/26/99

30. Name and address of person who completed cause of death (item 23a) (Type, Print)
Ronald P. Travitz MD 560 Riverside Dr Salisbury, MD

10

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUL 27 1999	Donna G Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25825

Certificate of Death

Reg. No.

briana Jones 215 55 0062

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Briana Alise Jones
2. Date of Death: Month July, Day 27, Year 1999
3. Time of Death: 1416
4e. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER
4b. City, Town, or Location of Death: SALISBURY
4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 212-55-0062
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday) Yrs.: If Under 1 Year Months 5 Days 16; If Under 24 Hrs. Hours Min.
8. Date of Birth (Month, Day, Year): Feb. 11, 1999
9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: Wicomico
10c. City, Town or Location: Salisbury
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 4258 Smith Road
10f. Zip Code: 21801
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) n/a; College (1-4or 5+)
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): n/a
16b. Kind of Business/Industry: n/a

17. Father's Name (First, Middle, Last):
18. Mother's Name (First, Middle, Maiden Surname): Kimberly Nicole Jones

19a. Informant's Name/Relationship (Type, Print): Kimberly N. Jones/mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4258 Smith Road - Salisbury, MD 21801

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Zion U.M. Church Cemetery
Date: 7/31/99
20c. Location - City or Town, State: Sharptown, Maryland

21. Signature of Funeral Service Licensee: Patricia A. Jolley
22. Name and Address of Facility: 1213 Jersey Road - Salisbury, JOLLEY MEMORIAL CHAPEL Maryland 21801

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. PULMONARY EDEMA/HYPOXIA

Due to (or as a consequence of):
b. CONGESTIVE HEART FAILURE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. CONGENITAL HEART DISEASE

Due to (or as a consequence of):
d. TRISOMY 18

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28e. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Stephen Cooper MD
29c. License number: D29965
29d. Date signed (Month, Day, Year): July 28, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): STEPHEN COOPER, M.D. 106 MILFORD ST SALISBURY, MD

State Registrar

31. Date filed (Month, Day, Year): JUL 28 1999
32. Registrar's Signature: Donna B Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25826

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Leon Karapetian
2. Date of Death (Month, Day, Year): July 31, 1999
3. Time of Death: 3:30 AM
4a. Facility Name (If not institution, give street and number): 212 Beaumont Road
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 127-24-2276
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 1, 1909
9. Birthplace (State or Foreign Country): Russia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 212 Beaumont Road
10f. Zip Code: 20904
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Civil & Structural Engineer
16b. Kind of Business/Industry: Engineering Design

17. Father's Name (First, Middle, Last): Avedis Karapetian
18. Mother's Name (First, Middle, Maiden Surname): Anna Aslanian

19a. Informant's Name/Relationship (Type, Print): Mary K. Alvord (daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13316 Tamworth Lane, Silver Spring, MD 20904

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory
Date: 7-31-99
20c. Location - City or Town, State: Beltsville, Maryland

21. Signature of Funeral Service Licensee: Ellen W. Rapp
22. Name and Address of Facility: Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): e. Aspiration Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Parkinsonism

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Rajindra K. Sarin MD
29c. License number: D13548
29d. Date signed (Month, Day, Year): 7.31.99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Rajindra K. Sarin, M. D., 10801 Lockwood Drive, #280, Silver Spring, MD 20901

State Registrar

31. Date filed (Month, Day, Year): AUG 02 1999
32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25827

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARY FRANCES KELLY
2. Date of Death Month: JUL Day: 30 Year: 1999
3. Time of Death: 10:15 PM
4a. Facility Name *(If not institution, give street and number)*: NATIONAL NAVAL MEDICAL CENTER
4b. City, Town, or Location of Death: BETHESDA
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 217-36-5558
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 82 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Apr. 27, 1917
9. Birthplace *(State or Foreign Country)*: Scranton, PA

Usual Residence of Decedent

10a. State: none
10b. County: none
10c. City, Town or Location: Washington
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 5863 Chevy Chase Pkwy., N.W.
10f. Zip Code: 20015
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1942-1966
13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*
Elementary/Secondary (0-12):
College (1-4or 5+): 5+
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Teacher
18b. Kind of Business/Industry: Catholic Univ.

17. Father's Name *(First, Middle, Last)*: James Patrick Finnerty
18. Mother's Name *(First, Middle, Maiden Surname)*: Agnes Gilligan

19a. Informant's Name/Relationship *(Type, Print)*: Harold V. Kelly/Husband
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5863 Chevy Chase Pkwy., N.W. Wash, DC 20015

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Metropolitan Crematory
Date: Aug. 1, 1999
20c. Location - City or Town, State: Alex., Virginia

21. Signature of Funeral Service Licensee: Amy C. Wa
22. Name and Address of Facility: DeVol Funeral Home, 2222 Wisconsin Ave., N.W., Washington, D.C. 20007

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. DIALATED CARDIOMYOPATHY
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
26a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: LT, MC, USNR — Erich Wedam, MD
29c. License number: RES-000
29d. Date signed *(Month, Day, Year)*: 31 July 1999
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): ERICH FRANCIS WEDAM, LT, MC, USNR — NATIONAL NAVAL MEDICAL CENTER, BETHESDA, MD 20889-5600

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 03 1999
32. Registrar's Signature: G. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25828

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: David Korn

2. Date of Death Month / Day / Year: July 30, 1999

3. Time of Death: 1:05 P.M.

4a. Facility Name *(If not institution, give street end number)*: Hebrew Home of Greater Washington

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 085-28-2994

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 65 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: April 27, 34

9. Birthplace *(State or Foreign Country)*: Poland

Usual Residence of Decedent

10a. State: Maryland | 10b. County: Montgomery | 10c. City, Town or Location: Rockville | 10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street end Number: 6121 Montrose Rd. | 10f. Zip Code: 20852 | 10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) | College (1-4or 5+): 5+

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: University Proffessor

16b. Kind of Business/Industry: Education

17. Father's Name *(First, Middle, Last)*: Josef Korn

18. Mother's Name *(First, Middle, Maiden Surname)*: Sara Golda Neiss

19a. Informant's Name/Relationship *(Type, Print)*: Maria Korn/wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3460 S.Ocean Blvd.#514 Palm Beach,FL 33480

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other piece)*: Adas Israel Cemetery | Date: 8/1

20c. Location - City or Town, State: Washington, DC.

21. Signature of Funeral Service Licensee: [signature]

22. Name end Address of Facility: Takoma Funeral Home. 254 Carroll St. NW Washington,DC. 20012

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset end Death
Immediate Cause (Final disease or condition resulting in death) a.	ACUTE RENAL FAILURE	MONTHS
Due to (or as a consequence of): b.	URETERAL OBSTRUCTION	MONTHS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or es e consequence of): c.	METASTATIC CARCINOMA OF PROSTATE	YEARS
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CORONARY ARTERY DISEASE

ADULT ONSET DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Menner of Death: 1 ☒ Netural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)* | 28b. Time of Injury M | 28c. Injury at Work? 1 ☐ Yes 2 ☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)* | 28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred et the time, dete end piece, end due to the cause(s) and menner es steted. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, In my opinion, death occurred et the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D05885

29d. Date signed *(Month, Day, Year)*: 07/30/99

30. Name end address of person who completed ceuse of death (Item 23a) (Type, Print): STEVEN LIPSON 6121 MONTROSE RD, ROCKVILLE

State Registrar

31. Date filed *(Month, Dey, Year)*: AUG 02 1999

32. Registrer's Signeture: [signature]

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health end Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

30 (10)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25829

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Frederick William Kurz
2. Date of Death (Month, Day, Year): July 31, 1999
3. Time of Death: 3:00am
4a. Facility Name (If not institution, give street and number): Rockville Nursing Home
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-05-6393
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 81 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 9, 1917
9. Birthplace (State or Foreign Country): Washington D.C.

Usual Residence of Decedent

10a. State: Md.
10b. County: Montgomery
10c. City, Town or Location: Potomac
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 11721 Devilwood Drive
10f. Zip Code: 20854
10g. Citizen of What Country?: United States
11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Service Maintenance
16b. Kind of Business/Industry: Retail
17. Father's Name (First, Middle, Last): Charles G. Kurz
18. Mother's Name (First, Middle, Maiden Surname): Flora Kling
19a. Informant's Name/Relationship (Type, Print): Mary K. Anstead (sister)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11721 Devilwood Dr. Potomac, Md. 20854
20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory
Date: Aug. 4, 1999
20c. Location - City or Town, State: Alexandria, Va.
21. Signature of Funeral Service Licensee: Curtis E. Day
22. Name and Address of Facility: DeVol Funeral Home 10 East Deer Park Dr. Gaithersburg, Md. 20877

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Hypertensive Heart Disease
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Atrial Fibrillation
Due to (or as a consequence of):
c. Uremic Encephalopathy
Due to (or as a consequence of):
d. Parkinsons Disease

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Depression

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [✓] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Thomas V. Joseph
29c. License number: D0047330
29d. Date signed (Month, Day, Year): 8/2/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Thomas Joseph M.D. 50 W. EDMONSTON DR. ROCKVILLE, MD 20852

State Registrar

31. Date filed (Month, Day, Year): AUG 03 1999
32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25830

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Henrietta R. Ker
2. Date of Death Month August Day 1 Year 1999
3. Time of Death: 4:15 AM
4a. Facility Name (If not institution, give street and number): Long View Nursing Home
4b. City, Town, or Location of Death: Manchester
4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 225-66-4979
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): August 9, 1909
9. Birthplace (State or Foreign Country): D.C.

Usual Residence of Decedent

10a. State: Maryland
10b. County: Carroll
10c. City, Town or Location: Manchester
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3332 Main Street
10f. Zip Code: 21102-0890
10g. Citizen of What Country?: United States

11. Meritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife
16b. Kind of Business/Industry: own home

17. Fether's Name (First, Middle, Last): Isaac S.K. Reeves
18. Mother's Name (First, Middle, Maiden Surname): Margaret Hoblitzel

19a. Informant's Name/Relationship (Type, Print): Mr. Keith R. Ker - Son
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 6633 Wind Ridge Road Mt. Airy, MD 21771

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Arlington National Cem.
Date: 8/5/99
20c. Location - City or Town, Stete: Arlington, VA

21. Signature of Funerel Service Licensee: James B Corey
22. Name and Address of Facility: Burrier-Queen Funeral Directors, P.A. 1212 W. Old Liberty Road Winfield, MD 21784

Physician /Medical Examiner

23a. Part I. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such es cerdiec or respiratory arrest, shock, or heert failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate cause (Final disease or condition resulting in death)
a. cardiomyopathy ~ 6 yrs
Due to (or es e consequence of):
b. chronic obstructive pulmonary dis ~ 15 yrs
Due to (or as a consequence of):
c.
Due to (or as e consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uas contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was en eutopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings eveileble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Menner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, offica building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and placa, and due to the ceuse(s) end manner steted.

29b. Signeture and title of certifier: ▶ [illegible] MD
29c. License number: D51705
29d. Date signed (Month, Day, Year): 8-4-1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): M. PANSURIYA, MD 419F Malcolm Dr, Westminster MD 21157

State Registrar

31. Date filed (Month, Day, Year): AUG 04 1999
32. Registrar's Signature: ▶ Geneva G. Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25831

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Dorotha May Keyser
2. Date of Death: Month July Day 30 Year 1999
3. Time of Death: 7:55 a.m.
4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 212-10-8230
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 31, 1921
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 9125 Bethel Road
10f. Zip Code: 21702
10g. Citizen of What Country? USA

11. Meritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 6 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): self
16b. Kind of Business/Industry: homemaker

17. Father's Neme (First, Middle, Last): John Wesley Hartsock
18. Mother's Name (First, Middle, Meiden Surname): Bertha May Keller

19a. Informent's Neme/Reletionship (Type, Print): Rosalie Garver, daughter
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9106 Hamburg Road, Frederick, MD 21702

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Plece of Disposition (Name of cemetery, cremetory or other place): Resthaven Memorial Gardens | Date: 8/3/99
20c. Location - City or Town, Stete: Frederick, Maryland

21. Signature of Funerel Service Licensee: Ryan M. Berger MO0999
22. Neme end Address of Facility: Keeney and Basford Funeral Home, 106 East Church Street, Frederick, MD 21701

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on each line.

		Approximete Intervel Between Onset and Deeth
Immediete Ceuse (Finel diseese or condition resulting in deeth) e.	Hyperkalemia	days
Due to (or es a consequence of): b.	Acute Renal Failure	days
Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last — Due to (or es a consequence of): c.	Hepatorenal Syndrome	week
d.	Cancer Unknown Primary Metastatic to the liver	Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: COPD / TOBACCO ABUSE; ANEMIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings eveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No

26. Plece of Deeth (Check only one): Hospitel: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Yeer) | 28b. Time of Injury M | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) | 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner as stated. 2☐ Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, dete end piece, and due to the cause(s) and menner steted.

29b. Signeture end title of certifier: MD
29c. License number: D47556
29d. Date signed (Month, Day, Year): 7/31/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): WILLIAM H. JOHNSON MD, 172 THOMAS JOHNSON DRIVE, FREDERICK, MD 21702

State Registrar

31. Date filed (Month, Dey, Yeer): AUG 02 1999
32. Registrer's Signeture: B. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25832

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Howard Dague Koontz

2. Date of Death (Month, Day, Year): July 26 1999

3. Time of Death: 1750

4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 232-60-2642

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 62 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 1-13-1937

9. Birthplace (State or Foreign Country): West Va.

Usual Residence of Decedent

10a. State: De.

10b. County: Sussex

10c. City, Town or Location: Delmar

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: Rt. 1 Box 447 BB-1

10f. Zip Code: 19940

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondary (0-12):

College (1-4or 5+): 1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Heavy Equipment operator

16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): Harold Lee Koontz

18. Mother's Name (First, Middle, Maiden Surname): Margaret Dague

19a. Informant's Name/Relationship (Type, Print): Sandra C. Koontz, Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. 1 Box 447 BB-1 Delmar, De. 19940

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Limestone Presbyterian

Date: 8-1-99

20c. Location - City or Town, State: Limestone, W. VA.

21. Signature of Funeral Service Licensee: William M. Short

22. Name and Address of Facility: Short FUNERAL HOME, INC. 13 E. Grove St. Delmar, De. 19940

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Adenocarcanoma

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Metastasis to Brain

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D54127

29d. Date signed (Month, Day, Year): 7/27/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Alan DAVIS 3 Bistibe Blvd Delmar 21875

State Registrar

31. Date filed (Month, Day, Year): JUL 29 1999

32. Registrar's Signature: [signature] B Sparks

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Howard Koontz

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

(over) 6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25833

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Shriley Jean Krause
2. Date of Death Month Day Year: Aug 4 1999
3. Time of Death: 12:56PM
4a. Facility Name (If not institution, give street and number): Sacred Heart Hospital
4b. City, Town, or Location of Death: Cumberland
4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 220-32-4624
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 63 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MARCH 23 1936
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ALLEGANY
10c. City, Town or Location: CUMBERLAND
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 13603 YUMA STREET S.W.
10f. Zip Code: 21502
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOME MAKER
16b. Kind of Business/Industry: HOME MAKER

17. Father's Name (First, Middle, Last): NORMAN RAY VANMETER
18. Mother's Name (First, Middle, Maiden Surname): BELVA KROTHERS

19a. Informant's Name/Relationship (Type, Print): RONALD KRAUSE HUSBAND
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13603 YUMA STREET CUMBERLAND MARYLAND 21502

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): CUMBERLAND CREMATORY — Date: AUGUST 7 1999
20c. Location - City or Town, State: CUMBERLAND MARYLAND

21. Signature of Funeral Service Licensee: Dale L. Merritt
22. Name and Address of Facility: MERRITT-ADAMS FUNERAL HOME P.A. 404 DECATUR STREET CUMBERLAND MARYLAND

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Arteriosclerotic heart disease — Uk yrs
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Chronic bronchitis; Mild obesity

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☒ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Dpty Med Ex D 09157
29c. License number
29d. Data signed (Month, Day, Year): AUGUST 4 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Paul Snow, M.D. 124 w 3rd st Cumberland Md 21502

State Registrar

31. Data filed (Month, Day, Year): AUG 0 6 1999
32. Registrar's Signature: Bonnie G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25834

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Anne Marie LaFrance
2. Date of Death Month Day Year: July 29, 1999
3. Time of Death: 3:55PM
4a. Facility Name *(If not institution, give street and number)*: 113 Floral Drive
4b. City, Town, or Location of Death: Gaithersburg
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 212-36-4400
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 66 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: August 27, 1932
9. Birthplace *(State or Foreign Country)*: Canada

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Gaithersburg
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 113 Floral Drive
10f. Zip Code: 20877
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): ; College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Buyer
16b. Kind of Business/Industry: Electronics

17. Father's Name *(First, Middle, Last)*: Bernard Patrick Power
18. Mother's Name *(First, Middle, Maiden Surname)*: Elizabeth Mary Barry

19a. Informant's Name/Relationship *(Type, Print)*: Elizabeth Shannon/Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 20302 Cedar Hurst Way, Germantown, Maryland 20876

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other *(Specify)* Entombment
20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Gate of Heaven Mausoleum — Date: August 2, 1999
20c. Location - City or Town, State: Silver Spring, Maryland

21. Signature of Funeral Service Licensee: Michelle E. Hagan M00846
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20805-2805

Physician Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Hepatic Failure	2 Weeks
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.	Metastatic Breast Cancer	2 Years
Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier
29c. License number: PA07631
29d. Date signed *(Month, Day, Year)*: July 30, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Cheryl Aylesworth, M.D. 6900 Georgia Avenue, N.W., Washington, D.C. 20307

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 03 1999
32. Registrar's Signature: James G. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25835

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): George Vernon Lamoy
2. Date of Death (Month, Day, Year): August 3, 1999
3. Time of Death: 4:25 PM
4a. Facility Name (If not institution, give street and number): Lorien Rehabilitation & Nursing Center
4b. City, Town, or Location of Death: Columbia
4c. County of Death: Howard

Funeral Director

5. Social Security Number: 076-14-4928
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 26, 1921
9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Howard
10c. City, Town or Location: Columbia
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 6079 Moongong Court
10f. Zip Code: 21045
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Chemist
16b. Kind of Business/Industry: U.S. Space Program

17. Father's Name (First, Middle, Last): Vernon Lamoy
18. Mother's Name (First, Middle, Maiden Surname): Margaret Smith

19a. Informant's Name/Relationship (Type, Print): Curtis Daniel Lamoy (son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 720 Beacon Hill Terrace, Gaithersburg, MD 20878

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory
Date: 8-4-99
20c. Location - City or Town, State: Beltsville, Maryland

21. Signature of Funeral Service Licensee: Carol A DeLorme
22. Name and Address of Facility: Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, Maryland 20910

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Pneumonia	2 weeks
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Dysphagia	1 Month
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Peripheral Vascular Disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Sanjay P. Shah, MD
29c. License number: D0052940
29d. Date signed (Month, Day, Year): AUG 03 99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Sanjay P. Shah, M. D., 10805 Hickory Ridge Road, #210, Columbia , MD 21044

State Registrar

31. Date filed (Month, Day, Year): AUG 04 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25836

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Louise U. Landphair
2. Date of Death (Month, Day, Year): August 2, 1999
3. Time of Death: 7:00AM
4a. Facility Name (If not institution, give street and number): 7501 Carroll Ave.
4b. City, Town, or Location of Death: Takoma Park
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 298-40-9953
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 91 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 14, 1907
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Takoma Park
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 7501 Carroll Ave.
10f. Zip Code: 20912
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): School Teacher
16b. Kind of Business/Industry: Education

17. Father's Name (First, Middle, Last): Martin L. Mcquown
18. Mother's Name (First, Middle, Maiden Surname): Louise B. Buterbaugh

19a. Informant's Name/Relationship (Type, Print): Theodore Landphair/son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7501 Carroll Ave. Takoma Park, MD. 20912

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): No. Virginia Crematory — Date: 8/3
20c. Location - City or Town, State: Arlington, VA.

21. Signature of Funeral Service Licensee: Richard D. Byrd
22. Name and Address of Facility: Takoma Funeral Home. 254 Carroll St. NW. Washington, DC. 20012

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Progressive Dementia — Due to (or as a consequence of): — Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. — Due to (or as a consequence of):
c. — Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Wasting

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: W. Davis MD
29c. License number: MD11075
29d. Date signed (Month, Day, Year): 8/4/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. William Davis, MD. 4910 Mass Ave. NW. Washington, DC.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): AUG 05 1999
32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25837

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MIKE LANG
2. Date of Death (Month, Day, Year): JULY 29 1999
3. Time of Death: 0147
4a. Facility Name (If not institution, give street and number): The Johns Hopkins Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: NONE

Funeral Director

5. Social Security Number: 229-35-8492
6. Sex: XX M 2☐ F
7. Age (In yrs. last birthday): 33 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 16, 1966
9. Birthplace (State or Foreign Country): China

Usual Residence of Decedent

10a. State: Virginia
10b. County: Prince William
10c. City, Town or Location: Manassas
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7817 Garner Drive
10f. Zip Code: 20109
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Asian

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Waiter
16b. Kind of Business/Industry: Restaurant

17. Father's Name (First, Middle, Last): Wen Lu Lang
18. Mother's Name (First, Middle, Maiden Surname): Li Ying Wang

19a. Informant's Name/Relationship (Type, Print): Lisa Lang (Sister)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5899 S. 6th St., Falls Church, Va. 22041

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): National Mem. Park
Date: 8/1/99
20c. Location - City or Town, State: Falls Church, Virginia

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Arlington Funeral Home - Arlington, Va. 22203 3901 North Fairfax Drive

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. METASTATIC ADENOCARCINOMA, UNKNOWN PRIMARY	3 WEEKS
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

PERICARDIAL EFFUSION

ACUTE LEFT PARIETAL INFARCTION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MProwell, MD
29c. License number: RES-000
29d. Date signed (Month, Day, Year): JULY 29, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): T. PROWELL, MD JOHNS HOPKINS 600 N. WOLFE ST BALTIMORE, MD 21287

State Registrar

31. Date filed (Month, Day, Year): AUG 02 1999
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25838

Certificate of Death Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: CLIFTON E LEAR
2. Date of Death Month: AUGUST Day: 2 Year: 1999
3. Time of Death: 0844
4e. Facility Name *(If not institution, give street and number)*: SHADY GROVE ADVENTIST HOSPITAL
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 215-26-3016
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 66 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Jan 27, 1933
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Md
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 616 Douglas Ave,
10f. Zip Code: 20850
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*
Elamantary/Secondary (0-12): 10th Grade
College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use ratired)*: Cook
16b. Kind of Business/Industry: Restaurant

17. Father's Name *(First, Middle, Last)*: William Lear
18. Mother's Name *(First, Middle, Maidan Surname)*: Ola Martin

19a. Informant's Name/Relationship *(Type, Print)*: Evelyn Genies (Cousin)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 15015 Seneca Rd, Germantown. Md 20874

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Lincoln Park Cem.
Date: 8/13/99
20c. Location - City or Town, State: Rockville, Md

21. Signature of Funeral Service Licensee: George R. Snowden
22. Name and Address of Facility: Snowden Funeral Home P.A. 20850
246 N. Washington St, Rockville, Md

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or haart failure. List only one causa on each lina.

Approximate Intarval Batween Onset and Death

Immediata Causa (Final disease or condition resulting in death)
a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Dua to (or as a consequanca of):

Sequentially list conditions, if any, leading to immadiata cause. Entar Underlying Causa (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceusa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was cese referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Daath *(Check only one)*
Hospital: 1 [ ] Inpatient 2 [X] Emergency Room/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Homa 5 [ ] Rasidence 6 [ ] Other *(Specify)*

27. Manner of Daath: 1 [X] Natural 2 [ ] Accidant 3 [ ] Suicide 4 [ ] Homicida 5 [ ] Pending Investigation 6 [ ] Could not be datarmined

28a. Data of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yas 2 [ ] No
28d. Dascriba how injury occurred
28a. Place of Injury - At homa, farm, streat, factory, office building, atc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician**: To the best of my knowledga, daath occurred at the time, date and place, and due to tha causa(s) and manner as stated. 2 [X] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, daath occurred at tha tima, data and place, and dua to the causa(s) and mannar statad.

29b. Signature and title of certifier: (OME)
29c. License number: D15236
29d. Date signed *(Month, Day, Year)*: AUGUST 2, 1999

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): CARL MARGOLIS, M.D. (OME) 11125 ROCKVILLE PIKE, ROCKVILLE, MD 20852

State Registrar

31. Date filed *(Month, Day, Yeer)*: AUG 05 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

6

4

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25839

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): George Leshner
2. Date of Death: Month July, Day 30, Year 1999
3. Time of Death: 10:50 PM
4a. Facility Name (If not institution, give street and number): SHADY GROVE ADVENTIST HOSPITAL
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 027-08-0538
6. Sex: 1☐ M 2☐ F — X
7. Age (In yrs. last birthday): 86 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb.20,1913
9. Birthplace (State or Foreign Country): Massachusetts

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1☐ Yes 2☐ No — X
10e. Street and Number: 8 Baltimore Rd.
10f. Zip Code: 20850
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced — XX
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — X — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No — X — Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Owner/Operator
16b. Kind of Business/Industry: Retail Food

17. Father's Name (First, Middle, Last): Harry Leshner
18. Mother's Name (First, Middle, Meiden Surname): Miriam Gabowitz

19a. Informent's Name/Relationship (Type, Print): Linda Revzan/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11400 Beechgrove Ln., Potomac, MD 20854

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) — X
20b. Place of Disposition (Name of cemetery, crematory or other piece): Judean Memorial Gardens
Date: Aug 2, 1999
20c. Location - City or Town, State: Olney, MD

21. Signeture of Funeral Servica Licensee: ▶ D. Kruvant
22. Name and Address of Facility: Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike, Rockville, MD 20852

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

		Approximate Interval Between Onset end Death
Immediate Cause (Final disease or condition resulting in death)	a. VENTRICULAR FIBRILLATION	MINUTES
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediete ceuse. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last	b. HYPERKALEMIA	TWO HOURS
Due to (or es e consequence of):		
	c. ACUTE RENAL FAILURE	UNKNOWN
Due to (or as a consequence of):		
	d. CONGESTIVE HEART FAILURE	UNKNOWN

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☑ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred et the time, dete and place, and due to the cause(s) end manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date and piece, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: ▶ Yuri a. Deychak MD
29c. License number: 041311
29d. Date signed (Month, Day, Year): JULY 30, 1999

30. Name and address of person who completed ceuse of deeth (Item 23e) (Type, Print): YURI A. DEYCHAK MD 6410 ROCKLEDGE DR. BETHESDA, MARYLAND

State Registrar

31. Date filed (Month, Dey, Yeer): AUG 03 1999
32. Registrar's Signature: ▶ Donna G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25840

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Richard Alan Levine

2. Date of Death (Month, Day, Year): July 31, 1999

3. Time of Death: 3:50 PM

4a. Facility Name (If not institution, give street and number): SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 578-54-7434

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 55 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb. 21, 1944

9. Birthplace (State or Foreign Country): Washington DC

Usual Residence of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Gaithersburg

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 18 Keystone Dr.

10f. Zip Code: 20878

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify: X

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 5

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Vice President

16b. Kind of Business/Industry: Communications

17. Father's Name (First, Middle, Last): George Levine

18. Mother's Name (First, Middle, Maiden Surname): Martha Weinstein

19a. Informant's Name/Relationship (Type, Print): Stephanie Levine/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 18 Keystone Dr., Gaithersburg, MD 20878

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): King David Memorial Grdn. | Date: 8/2/99

20c. Location - City or Town, State: Falls Church, VA

21. Signature of Funeral Service Licensee: ▶ D. King

22. Name and Address of Facility: Danzansky-Goldberg Memorial Chapels, Inc 1170 Rockville Pike, Rockville, MD 20852

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. NON SMALL CELL LUNG CANCER — 1 YEAR

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: ▶ Chitra Rajagopal M.D.

29c. License number: D 42452

29d. Date signed (Month, Day, Year): AUGUST 1, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): DR. CHITRA RAJAGOPAL, M.D. 18111, PRINCE PHILIP DRIVE, SUITE 327, OLNEY MD 20832

State Registrar

31. Date filed (Month, Day, Year): AUG 03 1999

32. Registrar's Signature: ▶ Donna B. Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

(b)

12

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25841

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: GARY (NMN) LODEMORE
2. Date of Death Month / Day / Year: AUGUST 1, 1999
3. Time of Death: 1:30PM
4a. Facility Name *(If not institution, give street and number)*: National Institutes of Health
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 231-19-5357
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 46 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Oct. 25, 1952
9. Birthplace *(State or Foreign Country)*: England

Usual Residence of Decedent

10a. State: N/A
10b. County: N/A
10c. City, Town or Location: Washington, DC
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1711 Massachusetts Ave. NW #228
10f. Zip Code: 20036
10g. Citizen of What Country?: United Kingdom

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+)
18a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Hairstylist
16b. Kind of Business/Industry: Hairdresser

17. Father's Name *(First, Middle, Last)*: Thomas Lodemore
18. Mother's Name *(First, Middle, Maiden Surname)*: Rosina Old

19a. Informant's Name/Relationship *(Type, Print)*: Christine Welch-Sister
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: Tree Tops, Yester Park, Chislehurst Kent, England BR75DQ

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetary, crematory or other place)*: National Crematory — Date: 8/5/99
20c. Location - City or Town, State: Falls Church, VA

21. Signature of Funeral Service Licensee
22. Name and Address of Facility: Joseph Gawler's Sons INC, 5130 Wisconsin Ave. NW, Washington, DC 20016

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e.	Multiorgansystem Failure	
Due to (or as a consequence of): b.	Hodgkin's Lymphoma	2 wks
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	Sepsis	3 wks
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

AIDS, Non Hodgkin's lymphoma
Renal Mucormycosis
Enterococcus UTI

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [✓] Yes 2 [ ] No
26. Place of Death *(Check only one)*: Hospital: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Maria Jison MD
29c. License number: D0054450
29d. Date signed *(Month, Day, Year)*: 8/1/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARIA JISON 9000 ROCKVILLE PIKE, BETHESDA, MARYLAND 20892

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 04 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25842

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Manuel Lopez
2. Date of Death: Month 07 Day 28 Year 1999
3. Time of Death: 1415
4a. Facility Name (If not institution, give street and number): University of Maryland Medical System
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 092-22-6365
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 68 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 18, 1930
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Florida
10b. County: Orange
10c. City, Town or Location: Winter Park
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1257 Serena Drive
10f. Zip Code: 32789
10g. Citizen of What Country?: U.S.A

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [X] Yes 2 [ ] No Specify: Spain
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Engineer
16b. Kind of Business/Industry: Engineering

17. Father's Name (First, Middle, Last): Joseph Lopez
18. Mother's Name (First, Middle, Maiden Surname): Josepha DoCampo

19a. Informant's Name/Relationship (Type, Print): Sheila Lopez-Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1257 Serena Dr., Winter Park, FL 32789

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): National Crematory
Date: 7/30/99
20c. Location - City or Town, State: Falls Church, VA

21. Signature of Funeral Service Licensee: Thomas E. Stonebraker
22. Name and Address of Facility: Joseph Gawler's Sons INC, 5130 Wisconsin Ave. NW, Washington, DC 20016

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. non-Hodgkin's lymphoma
Due to (or as a consequence of):
b. septicemia
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. small bowel infarction
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
acute respiratory distress syndrome
renal failure

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature], M.D.
29c. License number: P12400
29d. Date signed (Month, Day, Year): 7/28/99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Christopher Gannon 22 Saint Greene Street Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): AUG 02 1999
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

12

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: #17 PER F.H. G774 8-21-99 WR.

Certificate of Death

Reg. No. 99 25843

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James Francis Lynagh

2. Date of Death: Month July Day 30 Year 1999

3. Time of Death: 1:20 AM

4a. Facility Name (If not institution, give street and number): Manor Care - Wheaton

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 216-44-3619

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 89 Yrs.

If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 27, 1910

9. Birthplace (State or Foreign Country): Washington,D.C.

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 3705 Woodridge Avenue

10f. Zip Code: 20902

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Certified Public Accountant

16b. Kind of Business/Industry: Federal Government

17. Father's Name (First, Middle, Last): JOHN LYNAGH Patrick H. Lynagh

18. Mother's Name (First, Middle, Maiden Surname): Elizabeth O'Neill

19a. Informant's Name/Relationship (Type, Print): Patricia H. Lynagh (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3705 Woodridge Avenue Silver Spring,Maryland 20902

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cemetery

Date: 8/2/99

20c. Location - City or Town, State: Silver Spring,Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd.,W.,Silver Spring,MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cholangiocarcinoma — Three Months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atherosclerotic Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D37975

29d. Date signed (Month, Day, Year): July 30, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jeffrey D. Indrisano, M.D. 10801 Lockwood Drive Silver Spring,Maryland 20901

State Registrar

31. Date filed (Month, Day, Year): AUG 02 1999

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10+1

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25844

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: NORMAN WALTER LITTLE
2. Date of Death Month Dey Yaer: July 31, 1999
3. Time of Death: 6:30 AM
4a Facility Name *(If not institution, give street and number)*: 1650 Exeter Rd.
4b. City, Town, or Location of Death: Westminster
4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 215-32-6749
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 65 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Deta of Birth *(Month, Day, Year)*: Feb 20, 1934
9. Birthplace *(State or Foreign Country)*: Maryland

Usuel Residence of Decedent

10a. Stete: Maryland
10b. County: Carroll
10c. City, Town or Location: Westminster
10d. Inside City Limits: 1☐ Yas 2☒ No
10e. Street and Number: 1650 Exeter Rd.
10f. Zip Code: 21157
10g. Citizen of Whet Country?: USA

11. Meritel Stetus: ☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Evar in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Datas:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Raca - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Eduestion *(Specify only highest grede completed)*: Elementery/Secondary (0-12): 11 | College (1-4or 5+): 0
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Built staircases for New Homes
16b. Kind of Business/Industry: Construction Taney Supply

17. Fethar's Name *(First, Middle, Last)*: Jesse Walter Little
18. Mother'a Name *(First, Middle, Melden Surneme)*: Margie Ecker

19a. Informent's Name/Relationship *(Type, Pnint)*: (Sister) Mary Catherine Little
19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 1650 Exeter Rd. Westminster, MD 21157

20e. Method of Disposition: 1☒ Buriei 2☐ Cremetion 3☐ Ramovel from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other piece)*: Meadow Branch Cemetery
Dete: 8-3
20c. Location - City or Town, Stete: Westminster, MD

21. Signature of Funerel Service Licensee: John K Ayler
22. Name and Address of Feciility: Pritts Funeral Home and Chapel, P.A. 412 Washington Rd. Westminster, MD 21157

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications that caused tha daath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximete Interval Between Onset and Deith

Immediate Cause (Finai disaasa or condition resulting in deeth)
a. Adeno Carcinoma of Stomach ~ 3 months
Due to (or es e consequence of):
b. Adeno Carcinoma Liver ~ 3 months

Sequentieily list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest
Due to (or es e consequence of):
c.
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was en eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings evaileble prior to completion of causa of death? 1☐ Yas 2☐ No

25. Was cese referred to medical exeminer? 1☐ Yes 2☒ No

28. Piece of Death *(Check only one)*: Hospital: 1☐ inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Mennar of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Date of injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, offica buiiding, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowiedge, deeth occurred et the time, date end piece, end due to the ceuse(s) and menner as stated. 2☐ **Medical Examiner**: On the basis of examination end/or investigetion, In my opinion, deeth occurred et the time, dete end piece, and due to the ceuse(s) end menner steted.

29b. Signatura and titia of certifiar: M. Pansuriya, MD
29c. License number: D 51705
29d. Dete signed *(Month, Day, Year)*: 8-2-1999

30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print): M. PANSURIYA, MD 419F Malcolm Dr, Westminster MD 21157

State Registrar

31. Data filed *(Month, Dey, Year)*: AUG 0 3 1999
32. Registrer's Signature: Geneva D. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylend Department of Health and Mentel Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28e-i show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funerel director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25845

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EDWARD E. LEWIS SR.

2. Date of Death: Month 07 Day 29 Year 99

3. Time of Death: 10:06pm

4a. Facility Name (If not institution, give street and number): UNIVERSITY OF MARYLAND MEDICAL SYSTEM

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: BALTIMORE CITY

Funeral Director

5. Social Security Number: 217-36-7593

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 58 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept.30,1940

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Adamstown

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 5419 Mountville Road

10f. Zip Code: 21710

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 11 / College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Carpenter

16b. Kind of Business/Industry: Residential/ Commercial Homes

17. Father's Name (First, Middle, Last): Charles Walter Lewis Sr.

18. Mother's Name (First, Middle, Maiden Surname): Evelyn Gertrude Mullican

19a. Informent's Neme/Reletionship (Type, Print): Kathy Deskins / Daughter

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5419 Mountville Road,Adamstown, Maryland 21710

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from Stete 4 [ ] Donation 5 [ ] Other (Specify)

20b. Plece of Disposition (Name of cemetery, crematory or other place): St. Pauls Methodist Cemetery

Dete: 8/2

20c. Location - City or Town, Stete: Laytonsville,Maryland

21. Signature of Funeral Service Licensee: Todd D. Wynne

22. Name and Address of Facility: Olin L. Molesworth P. A. Funeral Home 26401 Ridge Road, Damascus, Maryland 20872

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on eech line.

Approximete Interval Between Onset and Deeth

Immediete Cause (Finel diseese or condition resulting in deeth)

a. MULTISYSTEM ORGAN FAILURE — 1 Week

Due to (or es e consequence of):

b. SMALL AND LARGE INTESTINAL INFARCTION — 1 Week

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Ceuse (Diseese or Injury that Initieted events resulting in deeth) Lest

Due to (or as a consequence of):

c.

Dua to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Wes an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Deeth (Check only one): Hospitel: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Menner of Deeth: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and menner as stated. 2 [ ] **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner steted.

29b. Signature end title of certifier: MD

29c. License number: AU417643589995

29d. Date signed (Month, Day, Year): 07/29/99

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print): PERCY BOATENG 22 South Greene Street. Baltimore, Maryland

State Registrar

31. Dete filed (Month, Day, Year): AUG 02 1999

32. Registrer's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25846

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Ronald Frank LITTLE Sr
2. Date of Death Month Day Year: August 04, 1999
3. Time of Death: 4:19 pm

4a. Facility Name *(If not institution, give street and number)*: 5483 Baltimore National Pike
4b. City, Town, or Location of Death: Catonsville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 402-54-5275
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 58 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Sep 24, 1940
9. Birthplace *(State or Foreign Country)*: Kentucky

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Monrovia
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 4826 Ed McClain Road
10f. Zip Code: 21770
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No — If Yes, Give Year or Dates: 1958-1962
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): — College (1-4 or 5+): 1
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Director of Space Allocation
16b. Kind of Business/Industry: Retail Grocery Store

17. Father's Name *(First, Middle, Last)*: Reader LITTLE
18. Mother's Name *(First, Middle, Maiden Surname)*: Bernice McGRAW

19a. Informant's Name/Relationship *(Type, Print)*: Mrs. Sylvia E. Little/Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4826 Ed McClain Road, Monrovia, Maryland 21770

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Smithsburg Crematory — Date: Aug 9, 1999
20c. Location - City or Town, State: Smithsburg, Maryland

21. Signature of Funeral Service Licensee: Keith Lynn Roberson M00706
22. Name and Address of Facility: Keeney & Basford P.A. Funeral Home, 106 East Church St, Frederick, Maryland 21701

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute Myocardial Infarction — 10 minutes
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other *(Specify)* at work

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☒ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: P. Shapiro MD
29c. License number: D07186
29d. Date signed *(Month, Day, Year)*: August 05, 1999

30. Name and address of person who completed cause of death (Item 29e) (Type, Print): Philip J. Shapiro, M.D., 814 Tollhouse Avenue, Frederick, Maryland 21701

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 06 1999
32. Registrar's Signature: Donna G. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25847

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): PHILIP MARGOLIUS
2. Data of Death Month Day Year: 7.31.1999
3. Time of Death: 3:05 PM
4a. Facility Name (If not institution, give street and number): HOLY CROSS HOSPITAL
4b. City, Town, or Location of Death: SILVER SPRING
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 578.48.0299
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 63 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 06.21.1936
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: MONTGOMERY
10c. City, Town or Location: POTOMAC
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 11710 MILBURN DRIVE
10f. Zip Code: 20854
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1955-58
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): OWNER
16b. Kind of Business/Industry: LIQUOR

17. Father's Name (First, Middle, Last): ALBERT MARGOLIUS
18. Mother's Name (First, Middle, Maiden Surname): ROSE LEVIN

19a. Informant's Name/Relationship (Type, Print): JANE MARGOLIUS/WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11710 MILBURN DRIVE, POTOMAC, MARYLAND 20854

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): JUDEAN MEMORIAL GARDENS
Date: 8.1.99
20c. Location - City or Town, State: OLNEY, MARYLAND

21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. GANGRENOUS CHOLECYSTITIS — ONE WEEK

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: DIABETIC KIDNEY DISEASE; CHRONIC ARTERY DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Philip Jay Schwartz MD
29c. License number: MARYLAND D24398
29d. Date signed (Month, Day, Year): JULY 31, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PHILIP JAY SCHWARTZ MD 15225 SHADY GROVE ROAD Suite 302 ROCKVILLE, MARYLAND 20850

State Registrar

31. Date filed (Month, Day, Year): AUG 03 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

(b) 10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25848

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Janet C. McGinnis
2. Date of Death (Month, Day, Year): August 1, 1999
3. Time of Death: 2:45 AM
4a. Facility Name (If not institution, give street and number): Holy Cross Rehabilitation & Nursing Center
4b. City, Town, or Location of Death: Burtonsville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 185-14-9526
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 76 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 9, 1922
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Kensington
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4408 Dresden Street
10f. Zip Code: 20895
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): School Teacher
16b. Kind of Business/Industry: Public Education

17. Father's Name (First, Middle, Last): Andrew R. O'Hara
18. Mother's Name (First, Middle, Maiden Surname): Sara J. Lewis

19a. Informant's Name/Relationship (Type, Print): Jean R. O'Toole (sister)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as 10

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory
Date: 8-2-99
20c. Location - City or Town, State: Beltsville, Maryland

21. Signature of Funeral Service Licensee: Ellen W. Rapp
22. Name and Address of Facility: Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Intracranial hemorrhage
Due to (or as a consequence of):
b. subdural hematoma
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. fall downstairs
Due to (or as a consequence of):
d. End stage renal disease

DME

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: CHF, hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year): July 21, 1999
28b. Time of Injury: 0400 M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: fell downstairs
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Home
28f. Location (Street and Number or Rural Route Number, City or Town, State): 4405 Dresden St Kensington, md 20895

29a. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD DME
29c. License number: D 02428
29d. Date signed (Month, Day, Year): Aug 2, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): IRA N. BRECHER, MD, DME 2101 Medical Park Dr Silver Spring, MD 20902

State Registrar

31. Date filed (Month, Day, Year): AUG 03 1999
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25849

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Frank R. McWilliams
2. Date of Death (Month, Day, Year): July 31, 1999
3. Time of Death: 1:10 pm
4a. Facility Name (If not institution, give street and number): Suburban Hospital
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-28-9630
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 76 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 22, 1923
9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 4605 Harlan Street
10f. Zip Code: 20853
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1942 1946
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Engineer
16b. Kind of Business/Industry: Defense Contracting
17. Father's Name (First, Middle, Last): Hugh L. McWilliams
18. Mother's Name (First, Middle, Maiden Surname): Ellen Russell
19a. Informant's Name/Relationship (Type, Print): Linda Groves (Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12408 Needle Dr. Clarksburg, MD 20871
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Parklawn Memorial Park
Date: 8-4-99
20c. Location - City or Town, State: Rockville, MD
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Hines-Rinaldi 11800 New Hampshire Avenue Silver Spring, MD 20904

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. primary central nervous system lymphoma — 6 mo

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: 021531
29d. Date signed (Month, Day, Year): Aug 1, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): G. PETER PUSHKAS 11510 Old GEORGETOWN Rd Rockville MD 20852

State Registrar

31. Date filed (Month, Day, Year): AUG 03 1999
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed/filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

MC will from frank 7-31-99 18m (B) 20

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25850

Physician /Medical Examiner

Funeral Director

1. Decedent's Name *(First, Middle, Last)*: Mary Lee Montgomery

2. Date of Death — Month: July 23 Day Year: 1999

3. Time of Death: 10:55 A.M.

4a. Facility Name *(If not institution, give street and number)*: Holy Cross Hospital

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

5. Social Security Number: 579-16-0114

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 88 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 28, 1911

9. Birthplace *(State or Foreign Country)*: Washington, DC

Usual Residence of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 10000 Brunswick Avenue

10f. Zip Code: 20910

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): / College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Surgical Technician

16b. Kind of Business/Industry: Walter Reed Army Medical Center

17. Father's Name *(First, Middle, Last)*: William A. Lee

18. Mother's Name *(First, Middle, Maiden Surname)*: Emma Washington

19a. Informant's Name/Relationship *(Type, Print)*: Richard E. Lee - Nephew

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1146 17th St. N.E. Washington, D. C. 20002

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: National Crematory

Date: 8/3/99

20c. Location - City or Town, State: Falls Church, Virginia

21. Signature of Funeral Service Licensee: Thomas E. Hombaker

22. Name and Address of Facility: Joseph Gawler's Sons 5130 WI Ave. N.W. Washington, D. C. 20016

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Septicemia — Days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Rheumatoid Arthritis — years

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in *my* opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D50678

29d. Date signed *(Month, Day, Year)*: 7/23/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): RAJIV BATRA M.D. 10801 Cockwood Dr. Silver Spring, MD 20901

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 02 1999

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25851

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Data of Daath Month Day Year	3. Tima of Death
AGUSTINA	MORALES	AUGUST 2, 1999	5:25 PM

4a. Facility Nama (If not institution, giva street and number)	4b. City, Town, or Location of Death	4c. County of Death
11428 HEREFORDSHIRE WAY	GERMANTOWN	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sax	7. Aga (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplaca (State or Foreign Country)
088-24-1013	1☐ M 2☒ F	71 Yrs.			Sept 28, 1927	Puerto Rico

Usual Residence of Decedent

10a. Stale	10b. County	10c. City, Town or Location	10d. Inside City Limita
Maryland	Montgomery	Germantown	1☐ Yes 2☒ No

10e. Sireet and Number	10f. Zip Code	10g. Citizen of What Country?
11428 Herefordshire Way	20876	United States

11. Marital Status	12. Was Decedent Evar in U.S. Armed Forcas?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Yaar or Dates:	1☒ Yes 2☐ No Specify: Puerto Rican	Specify: Hispanic

15. Decedent's Eduction (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondery (0-12)	College (1-4or 5+)		
	2	Homemaker	Own Home

17. Fathar's Nama (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Herminio Perez	Teresa Santana

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Streat and Number or Rural Route Number, City or Town, State, Zip Code)
Magda E. Morales, daughter	11428 Herefordshire Way, Germantown, MD 20876

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, Stala
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Metropolitan Crematory	Aug 5, 1999	Alexandria, Virginia

21. Signature of Funeral Service Licensee	22. Nama and Address of Facility
	DeVol Funeral Home 10 E. Deer Park Dr., Gaithersburg, MD 20877

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on eech line.

		Approximate Interval Between Onset and Death
Immediete Ceuse (Final disease or condition resulting in daath)	e. BREAST CANCER	7 YEARS
	Due to (or as a consequence of):	
	b. LIVER FAILURE	1 week
Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the ceuse of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of ceuse of death?
1☐ Yes 2☑ No	1☐ Yes 2☐ No

25. Was cese referred to medical examiner?	26. Plece of Deeth (Check only one)	
1☐ Yes 2☑ No	Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA	Other: 4☐ Nursing Home 5☑ Residenca 6☐ Othar (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how Injury occurred
1☑ Natural 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, streel, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29e. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and dua to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Joseph M. Haggerty MD	D32407	AUGUST 4, 1999

30. Name and addrass of person who completed cause of deeth (Item 23e) (Type, Print)
JOSEPH M. HAGGERTY, M.D., 9707 MEDICAL CENTER DRIVE, #300 ROCKVILLE, MARYLAND 20850

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
AUG 05 1999	Donna G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25852

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: SILVERIO PAEZ MORENO

2. Date of Death — Month: AUGUST Day: 2 Year: 1999

3. Time of Death: 0535

4a. Facility Name *(If not institution, give street and number)*: 111 CHARLES STREET

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 220-37-4813

6. Sex: 1 ☐ M 2 ☐ F — X

7. Age *(In yrs. last birthday)*: 53 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Date of Birth *(Month, Day, Year)*: JUNE 20, 1946

9. Birthplace *(State or Foreign Country)*: PARAGUAY

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: MONTGOMERY

10c. City, Town or Location: ROCKVILLE

10d. Inside City Limits: 1 ☐ Yes 2 ☐ No — X

10e. Street and Number: 111 CHARLES STREET

10f. Zip Code: 20850

10g. Citizen of What Country?: PARAGUAY

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☒ Yes 2 ☐ No — X — Specify:

14. Race - American Indian, Black, White, etc. — Specify: SPANISH

15. Decedent's Education *(Specify only highest grade completed)*

Elementary/Secondary (0-12):

College (1-4or 5+): 5+

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: PROFESSIONAL DETECTIVE

18b. Kind of Business/Industry: PARAGUAY GOVERNMENT

17. Father's Name *(First, Middle, Last)*: JUAN PAEZ

18. Mother's Name *(First, Middle, Maiden Surname)*: BENITA REMONA MORENO

19e. Informant's Name/Relationship *(Type, Print)*: NIDIA ESTIGARAIBIA (SISTER)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 111 CHARLES STREET - ROCKVILLE, MARYLAND 20850

20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: CEMENTERIO DEL ESTE

Date: 8/11/99

20c. Location - City or Town, State: ASUNCION, PARAGUAY

21. Signature of Funeral Service Licensee: Donald C. Stottlemyer

22. Name and Address of Facility: DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE-ROCKVILLE, MARYLAND 20852

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were eutopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other *(Specify)*

27. Menner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury: M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D15236

29d. Date signed *(Month, Day, Year)*: AUGUST 2, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): CARL MARGOLIS, M.D. (OME) 11125 Rockville Pike, Rockville, MD 20852

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 06 1999

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25853

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LORETTA MORRISON
2. Date of Death (Month, Day, Year): JULY 31 1999
3. Time of Death: 0545
4a. Facility Name (If not institution, give street and number): Suburban Hospital
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery County

Funeral Director

5. Social Security Number: 276-48-3521
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 49 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): September 29, 1949
9. Birthplace (State or Foreign Country): Ohio

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Bethesda
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7555 C-1 Spring Lake Drive
10f. Zip Code: 20817
10g. Citizen of What Country?: United States of America

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Administrative Coordinator
16b. Kind of Business/Industry: Benefits Company

17. Father's Name (First, Middle, Last): Thomas Hutchison
18. Mother's Name (First, Middle, Maiden Surname): Pauline Eakle

19a. Informant's Name/Relationship (Type, Print): Donald Morrison/ Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7555 C-1 Spring Lake Drive, Bethesda, Maryland 20817

20a. Method of Disposition: ☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Bergholz Cemetery | Date: August 3, 1999
20c. Location - City or Town, State: Bergholz, Ohio

21. Signature of Funeral Service Licensee: #M00690 Donald R Causer
22. Name and Address of Facility: Everhart Funeral Home 110 West Main Street, Richmond, Ohio 43944

Physician /Medical Examiner

23a. Part1. Enter the diseasa, or complications that caused the death. Do not entar tha moda of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lina. | Approximata Intarval Between Onset and Death

Immediate Causa (Final disease or condition resulting in death): a. METASTATIC COLON CANCER — 20 MONTHS
Dua to (or as a consequence of):
Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last: b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was casa referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only ona): Hospital: 1☑ Inpatiant 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Rasidence 6☐ Other (Specify)
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending investigation 6☐ Could not be datarmined
28a. Date of Injury (Month, Day Year) | 28b. Tima of Injury | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To tha best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner es stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, daath occurred at the time, data and place, end due to the cause(s) and menner stated.

29b. Signefure and title of certifier: Joseph M. Haggerty MD
29c. License number: D32407
29d. Date signed (Month, Day, Year): AUGUST 1ST 1999

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print): JOSEPH M. HAGGERTY 9707 MEDICAL CTR DR ROCKVILLE MD 20850

State Registrar

31. Data filed (Month, Day, Year): AUG 03 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25854

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Frederick Carl Miller
2. Data of Death Month Day Year: July 29, 1999
3. Time of Death: 0530
4a. Facility Name (If not institution, give street and number): Carroll County General Hospital
4b. City, Town, or Location of Death: Westminster
4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 218-07-7989
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 8,1920
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Carroll
10c. City, Town or Location: Hampstead
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 4804 Westfield Drive
10f. Zip Code: 21074
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Nevar Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forcas? 1☐ Yes 2☐ No If Yes, Give Yeer or Dates: WWII Korea
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12) | College (1-4or 5+): 2
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Manager
16b. Kind of Business/Industry: C&P Telephone Co

17. Father's Name (First, Middle, Last): August F.C. Miller
18. Mother's Neme (First, Middle, Maiden Surneme): Anna Katherine Dittman

19a. Informant's Neme/Relationship (Type, Print): Jean F. Miller, wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4804 Westfield Dr, Hampstead, Md 21074

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donation 5☐ Other (Specify)
20b. Piece of Disposition (Name of cemetery, cremetory or other piece): Hampstead Cemetery
Date: 8/2
20c. Location - City or Town, Stete: Hampstead, MD

21. Signeture of Funeral Service Licensee: Steven W Eline
22. Name and Address of Facility: Eline Funeral Home 934 South Main St, Hampstead, MD 21074

Physician /Medical Examiner

23a. Part1. Enter the disaesa, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart feilure. List only one cause on eech line. | Approximate Interval Between Onset and Death

Immediate Cause (Finel diseese or condition resulting in deeth): a. Metastatic Lung Ca — Months
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yas 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth: t☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated.

29b. Signetura and title of certifier: Herbert P. Henderson
29c. License number: D005,924
29d. Data signed (Month, Day, Year): 7-29-99

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Herbert P. Henderson Jr. MD 295 Stoner Ave Suite 307 Westminster MD 21157

State Registrar

31. Data filed (Month, Dey, Year): JUL 30 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25855

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Annabelle (NMN) May
2. Date of Death Month Day Year: August 3, 1999
3. Time of Death: 1:00 AM
4a. Facility Name *(If not institution, give street and number)*: 1400 Pinewood Dr.
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 220-26-6027
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 68 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Feb. 12, 1931
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1400 Pinewood Drive
10f. Zip Code: 21701
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: self
16b. Kind of Business/Industry: homemaker

17. Father's Name *(First, Middle, Last)*: Thomas C. Grimes
18. Mother's Name *(First, Middle, Maiden Surname)*: Eva K. Joy

19a. Informant's Name/Relationship *(Type, Print)*: Michael W. Rippeon, son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 17515 General Long Street Circle, Sharpsburg, MD 21782

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Resthaven Memorial Gardens — Date: 8/6/99
20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee: Ryan M. Berger
22. Name and Address of Facility: M00999 Keeney and Basford Funeral Home, 106 East Church Street, Frederick, MD 21701

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. A.S.C.V.D — Years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D35164
29d. Date signed *(Month, Day, Year)*: August 4, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Andrew GARICK, JR. MD 1080 Frederick, MD 21703.

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 05 1999
32. Registrar's Signature: B. Sparr

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25856

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Merle R. Mills

2. Dete of Deeth: Month August Dey 2 Year 1999

3. Time of Death: 1940

4a Facility Neme *(If not institution, give street and number)*: SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 214-28-4908

6. Sex: 1☑M 2☐F

7. Age *(In yrs. last birthday)*: 67 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Day, Year)*: Oct 14 1931

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Germantown

10d. Inside City Limits: 1☐Yes 2☑No

10e. Street end Number: 15531 Germantown Rd.

10f. Zip Code: 20874

10g. Citizen of What Country?: U.S.A.

11. Maritel Stetus: 1☐Never Merried 2☑Married 3☐Widowed 4☐Divorced

12. Wes Decedent Ever in U,S. Armed Forces? 1☑Yes 2☐No If Yes, Give Year or Detes: 52-54

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☑No *Specify:*

14. Race - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Plumber

16b. Kind of Business/Industry: Plumbing

17. Fether's Neme *(First, Middle, Last)*: Clarence Mills

18. Mother's Neme *(First, Middle, Meiden Sumame)*: Bessie Reed

19a. Informent's Name/Reletionship *(Type, Print)*: Frances Mills/spouse

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 15531 Germantown Rd. Germantown, Md 20874

20a. Method of Disposition: 1☑Burial 2☐Cremetion 3☐Removel from State 4☐Donetion 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Darnestown Presbyterian Date: 8/6

20c. Location - City or Town, Stete: Darnestown, MD

21. Signeture of Funerel Service Licensee: ▶ Will D. Hilton

22. Name end Address of Facility: Hilton Funeral Home Box 86 Barnesville, Md 20838

Physician /Medical Examiner

23a. Pert I. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heert failure. List only one cause on each line.

Approximete Intervel Between Onset and Deeth

Immediate Ceuse (Finel disease or condition resulting in deeth)
e. cardio-pulmonary arrest — min

Due to (or es e consequence of):
b. hypovolemic shock — min

Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Last
Due to (or es e consequence of):
c. blood coagulopathy — hrs.

Due to (or es e consequence of):
d. surgery - abdominal aortic anewrysm — hrs.

Pert II. **Other significant conditions** contributing to deeth but not resulting in the underlying ceuse given in Part I.

seizure disorder

asbestosis

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

24e. Wes en eutopsy performed? 1☐Yes 2☑No

24b. Were eutopsy findings eveilebie prior to completion of ceuse of death? 1☐Yes 2☑No

25. Wes case referred to medical exeminer? 1☐Yes 2☑No

26. Place of Deeth *(Check only one)*: Hospital: 1☑Inpetient 2☐ER/Outpetient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Menner of Deeth: 1☑Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined

28e. Dete of Injury *(Month, Day Year)*

28b. Time of injury M

28c. Injury et Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, offica building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☑**Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end menner es steted. 2☐**Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner steted.

29b. Signeture and title of certifier: ▶ Robert L. Fox physician

29c. License number: D 0024773

29d. Date signed *(Month, Day, Year)*: August 2, 1999

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print): Robert L. Fox, M.D. 9715 Medical Center Drive, Rockville, Maryland

State Registrar

31. Dete filed *(Month, Day, Year)*: AUG 05 1999

32. Registrer's Signeture: ▶ Geneva G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland Department of Health end Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the deeth certificete be executed within 24 hours after deeth.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25857

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Betty Irene MILLS
2. Date of Death Month Day Year: July 27, 1999
3. Time of Death: 1730
4a. Facility Name *(If not institution, give street and number)*: Homewood Retirement Center
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 479-16-2855
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 77 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: Feb. 12, 1922
9. Birthplace *(State or Foreign Country)*: Iowa

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Germantown
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 11061 Kingsarrow Court
10f. Zip Code: 20876
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yas 2☒ No If Yas, Giva Year or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, atc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Giva kind of work done during most of working lifa. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Fathar's Nama *(First, Middla, Last)*: Olin MURPHY
18. Mothar's Nama *(First, Middle, Maiden Surnama)*: Mattie PAULSON

19a. Informant's Name/Ralationship *(Type, Print)*: Timothy Mills, Son
19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 11061 Kingsarrow Court, Germantown, Md. 20876

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from Stata 4☐ Donation 5☐ Othar *(Specify)*
20b. Place of Disposition *(Nama of cematary, crematory or other place)*: Springfield National Cem., Date: July 30, 1999
20c. Location - City or Town, Stata: Sprinfield, Mo.

21. Signature of Funeral Sarvice Licensee: ▶ Richard E. Gray M00255
22. Nama and Address of Facility: Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick, Md. 21701

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that ceused tha death. Do not enter tha moda of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only ona ceuse on aach line.

		Approximata Interval Between Onset and Death
Immediata Causa (Final diseasa or condition resulting in death) a.	sepsis	24 hrs.
Dua to (or as a consequence of): b.	Acute Urinary Retention	~1 yr.
Sequentially list conditions, if any, leading to immadiata causa. Entar Underlying Cause (Diseasa or injury that initiated events resulting in death) Last — Dua to (or as a consequence of): c.		
Dua to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa given in Part I.

atrial fibrillation
Dementia
Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was cese rafarrad to medical examiner? 1☐ Yas 2☒ No

26. Placa of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Homa 5☐ Residence 6☐ Othar *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Data of Injury *(Month, Day Year)* | 28b. Tima of Injury | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At homa, farm, street, factory, office building, etc. *(Specify)* | 28f. Location *(Street and Number or Rural Routa Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To tha best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and mannar as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the tima, date and place, and due to the cause(s) and manner stated.

29b. Signatura and title of certifier: ▶ Francis E. Becker MD
29c. Licensa number: D30496
29d. Data signed *(Month, Day, Year)*: July 28, 1999

30. Name and address of person who completed causa of death (Item 23a) (Type, Print): Francis E. Becker MD; 300 W 9th St; Frederick, Md.

State Registrar

31. Data filed *(Month, Day, Year)*: JUL 30 1999
32. Registrar Signature: ▶ Bonnie B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25858

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Mary Louise Moore

2. Dete of Death Month: July Dey: 26 Year: 1999

3. Time of Death: 0710

4e. Feclity Neme *(If not institution, give street end number)*: PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Deeth: SALISBURY

4c. County of Deeth: WICOMICO

Funeral Director

5. Social Security Number: 221-26-7059

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 60 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Day, Year)*: 4-15-1939

9. Birthpiece *(State or Foreign Country)*: DE.

Usuei Residence of Decedent

10a. Stete: De.

10b. County: Sussex

10c. City, Town or Location: Delmar

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: Rt.#1 Box 492B

10f. Zip Code: 19940

10g. Citizen of Whet Country?: USA

11. Maritel Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hlspenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12 / College (1-4or 5+):

16e. Decedent's Usuei Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Contractor

16b. Kind of Business/Industry: School Buses

17. Fether's Neme *(First, Middle, Last)*: Phillip J. Elliott

18. Mother's Neme *(First, Middle, Meiden Surname)*: Grace Whaley

19a. Informent's Neme/Reletionship *(Type, Print)*: Robert C. Moore, Husband

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: Rt. 1 Box 492B Delmar, De. 19940

20e. Method of Disposition: 1☐ Buriel 2☒ Cremetion 3☐ Removei from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Name of cemetery, crematory or other place)*: Cambridge Crematory

Dete: 7-29

20c. Location - City or Town, State: Cambridge, Md.

21. Signeture of Funerel Service Licensee: William M. Short

22. Neme end Address of Fecility: Short Funeral Home, Inc. 13 E. Grove St. Delmar, De. 19940

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert feilure. List only one ceuse on each line.

Approximete Interval Between Onset end Deeth

Immediete Ceuse (Finel diseese or condition resulting in death): e. CONGESTIVE HEART FAILURE — ONE YEAR

Due to (or es e consequenca of): b. CHRONIC LUNG DISEASE — ONE YEAR

Sequentielly list conditions, if eny, leading to immediete cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Last

Due to (or es e consequence of): c. ANEMIA — ONE YEAR

Due to (or es e consequence of): d. RENAL FAILURE — ONE YEAR

Pert II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Pert I.

23b. Did tobecco use contribute to the ceuse of deeth? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveilebie prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Wes cese referred to medicel exeminer? 1☐ Yes 2☒ No

26. Piece of Deeth *(Check only one)*: Hospitel: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Couid not be determined

28e. Dete of Injury *(Month, Dey Yeer)*

28b. Time of injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Phyaicien:** To the best of my knowledge, death occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the cause(s) end menner steted.

29b. Signeture end title of certifier: Ramesh Kr Agarwal

29c. License number: D54807

29d. Dete signed *(Month, Dey, Yeer)*: 7-26-99

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Ramesh Agarwal, M.D. 106 milford st. ste 104 salisbury, MD

State Registrar

31. Dete filed *(Month, Day, Year)*: JUL 27 1999

32. Registrer's Signeture: Geneva G Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Meryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

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Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

221-26-7059

Mary Moore

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25859

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Bradley G. Minner

2. Date of Death (Month, Day, Year): July 28, 1999

3. Time of Death: 8:30 A.M.

4a. Facility Name (If not institution, give street and number): 29983 Foskey Lane

4b. City, Town, or Location of Death: Delmar

4c. County of Death: Wicomico

Funeral Director

5. Social Security Number: 221-03-1149

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept. 23, 1913

9. Birthplace (State or Foreign Country): Delaware

Usual Residence of Decedent

10a. State: MD

10b. County: Wicomico

10c. City, Town or Location: Delmar

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 412 East East Street

10f. Zip Code: 21875

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 | College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Mechanic

16b. Kind of Business/Industry: Bus Co.

17. Father's Name (First, Middle, Last): Harry Minner

18. Mother's Name (First, Middle, Meiden Surname): Mary Pratt Minner

19a. Informent's Neme/Relationship (Type, Print): Ruth E. See/Daughter

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 29983 Foskey Lane Delmar, MD 21875

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): St. Stephens Cemetery | Date: 8-1-99

20c. Locetion - City or Town, State: Delmar, Delaware

21. Signature of Funeral Servica Licensee: ▶ Holly Short-Hannigan

22. Name and Address of Facility: Short Funeral Home, 13 E. Grove St. Delmar, DE 19940

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset end Death)

Immediate Cause (Final diseese or condition resulting in death): a. Metastatic Colon Cancer

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet Initiated events resulting in deeth) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Prostate Cancer

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one): Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred et the time, date and placa, and due to the cause(s) and menner es stated. 2 [ ] **Medical Examiner**: On the besis of exemination and/or investigetion, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶

29c. License number: D0050614

29d. Date signed (Month, Dey, Year): 7/29/99

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print): 1001 Pemberton Dr Suite 2A Salisbury MD 21801

State Registrar

31. Dete filed (Month, Day, Yeer): JUL 29 1999

32. Registrar's Signeture: Geneva G Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

8

(wk)

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25860

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ERNESTINE THOMAS MILLIGAN
2. Date of Death: Month AUGUST Day 4 Year 1999
3. Time of Death: 3:45AM
4a. Facility Name (If not institution, give street and number): MALLARD BAY CENTER
4b. City, Town, or Location of Death: CAMBRIDGE
4c. County of Death: DORCHESTER

Funeral Director

5. Social Security Number: 216-18-2332
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 94 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JULY 3, 1905
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10e. State: MARYLAND
10b. County: DORCHESTER
10c. City, Town or Location: HURLOCK
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 410 SOUTH MAIN STREET
10f. Zip Code: 21643
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SEAMSTRESS
16b. Kind of Business/Industry: GARMENT MANUFACTURING

17. Father's Name (First, Middle, Last): JAMES THOMAS
18. Mother's Name (First, Middle, Maiden Surname): THERESA LANKFORD

19a. Informant's Name/Relationship (Type, Print): EILEEN M. JONES/DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P. O. BOX 148, HURLOCK, MD 21643

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): UNITY WASHINGTON CEMETERY
Date: 8/6/99
20c. Location - City or Town, State: HURLOCK, MARYLAND

21. Signature of Funeral Service Licensee: Leonard D. Zeller
22. Name and Address of Facility: ZELLER FUNERAL HOME, P. O. BOX 207, 106 MAIN STREET, EAST NEW MARKET, MD 21631

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Lymphoma of Breast	1 yr
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CHF

Type 2 diabetes

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Michael J. Fadden MD
29c. License number: D-26388
29d. Date signed (Month, Day, Year): 8/4/99

30. Name and address of person who completed cause of death (item 23e) (Type, Print): MICHAEL J. FADDEN, M.D., 302 COLLINS AVENUE, HURLOCK, MD 21643

State Registrar

31. Date filed (Month, Day, Year): AUG 05 1999
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25861

Miller, Gilbert

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Gilbert K. Miller, Sr
2. Date of Death: Month August, Day 8, Year 1999
3. Time of Death: 12:28 am
4a. Facility Name (If not institution, give street and number): Greater Baltimore Medical Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 219-10-7435
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): Sept. 17, 1924
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: White Hall
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 915 Bernoudy Rd.
10f. Zip Code: 21161
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yeer or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9; College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Truck Driver
16b. Kind of Business/Industry: Oil Company

17. Father's Name (First, Middle, Last): Edward J. Miller
18. Mother's Neme (First, Middle, Maiden Surname): Dellie M. Hare

19a. Informant's Name/Relationship (Type, Print): Helen L. Miller/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 915 Bernoudy Rd., White Hall,MD 21161

20a. Method of Disposition: 1 [X] Buriel 2 [ ] Cremation 3 [ ] Removel from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Dulaney Valley Memorial Gardens; Date: Aug. 12, 1999
20c. Location - City or Town, Stete: Timonium, MD

21. Signature of Funeral Service Licensee: Helen L. Hartenstein
22. Name end Address of Facility: J.J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA 17349

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Ceuse (Final disease or condition resulting in death)	e. Acute Myocardial Infarction	50 min.
Due to (or as a consequence of):		
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest	b. Ischemic heart disease	
Due to (or es a consequence of):		
	c.	
Due to (or as e consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: End Stage Renal Disease; Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Wes an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? NA 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Homa 5 [ ] Residence 6 [ ] Other (Specify)

27. Menner of Death: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) end manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: Alvin N. Ann MD
29c. License number: D38182
29d. Date aigned (Month, Day, Year): 8/8/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 2 Hamill Rd Suite 344 Baltimore, MD 21210

State Registrar

31. Dete filed (Month, Day, Year): AUG 17 1999
32. Registrer's Signeture: Irene G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Amended # 8, MS per DA, 8/9/99, Allegany County

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25862

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Renee L Michael

2. Date of Death Month Day Year: Aug 5 1999

3. Time of Death: 2:15PM

4a. Facility Name (If not institution, give street and number): Memorial Hospital

4b. City, Town, or Location of Death: Cumberland

4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 215-26-7638

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 74 ~~75~~ Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug 18, ~~1923~~ 1924

9. Birthplace (State or Foreign Country): France

Usual Residence of Decedent

10a. State: MD

10b. County: Allegany

10c. City, Town or Location: Cumberland

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 108 Auburn Avenue

10f. Zip Code: 21502

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Ret. Senior Accountant

16b. Kind of Business/Industry: Tire Company

17. Father's Name (First, Middle, Last): nfn

18. Mother's Name (First, Middle, Maiden Surname): nmn

19a. Informant's Name/Relationship (Type, Print): Joseph D. Michael husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 108 Auburn Avenue;Cumberland, MD 21502

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Sunset Memorial Park

Date: 8/07/

20c. Location - City or Town, State: Cumberland, MD

21. Signature of Funeral Service Licensee: Nicholas J. Scarpelli

22. Name and Address of Facility: Scarpelli Funeral Home P.A. Cumberland, Maryland 21502

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart tailure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)
a. Multiple trauma — 1 day

Due to (or es a consequence of):

Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last
b.

Due to (or es a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year): Aug 4 99

28b. Time of Injury: 3:15P M

28c. Injury at Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred: Passanger in auto hit by on coming car broad side

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify): street

28f. Location (Street and Number or Rural Route Number, City or Town, State): Queen city drive, Cumb Md

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) end menner es stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and menner stated.

29b. Signeture and title of certifier: Paul Snow Dpty Med Ex

29c. License number: D09157

29d. Dete signed (Month, Day, Year): Aug 5 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Paul Snow M.D. 124 W. 3rd Street Cumberland MD 21502

State Registrar

31. Date filed (Month, Day, Year): AUG 0 6 1999

32. Registrar's Signature: Penny D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

6/6 MS

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25863

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DR. FREDERICK WILLIAM MILTENBERGER
2. Date of Death: Month AUGUST Day 3 Year 1999
3. Time of Death: 19:09 PM
4a. Facility Name (If not institution, give street and number): MEMORIAL HOSPITAL
4b. City, Town, or Location of Death: CUMBERLAND
4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 214-32-0840
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 66 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MAY 2 1933
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ALLEGANY
10c. City, Town or Location: CUMBERLAND
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 14701 SMOUSES MILL ROAD N.E.
10f. Zip Code: 21502
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: U.S.A.F.
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12+ College (1-4or 5+): 14
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SURGEON/THORACIC-VASCULAR
16b. Kind of Business/Industry: MEDICAL

17. Father's Name (First, Middle, Last): JAMES EDWARD MILTENBERGER
18. Mother's Name (First, Middle, Maiden Surname): MARY AGNES REPHANN

19a. Informant's Name/Relationship (Type, Print): MARY MILTENBERGER WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14701 SMOUSES MILL ROAD N.E. CUMBERLAND MD. 21502

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): CUMBERLAND CREMATORY
Date: AUGUST 5 1999
20c. Location - City or Town, State: CUMBERLAND MARYLAND

21. Signature of Funeral Service Licensee: ▶ Dale L. Merritt
22. Name and Address of Facility: MERRITT-ADAMS FUNERAL HOME P.A. 404 DECATUR STREET CUMBERLAND MARYLAND

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. MYOCARDIAL INFARCATION — MINUTES
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Peter Halmos
29c. License number: D0Y096
29d. Date signed (Month, Day, Year): August 4. 1999.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. PETER HALMOS 600 MEMORIAL AVE. MEMORIAL HOSPITAL CUMBERLAND MARYLAND 21502

State Registrar

31. Date filed (Month, Day, Year): AUG 0 6 1999
32. Registrar's Signature: ▶ Deborah D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

FREDERICK MILTENBERGER 214320840

11

MD

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25864

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ERVIN WILBUR NELSEN
2. Date of Death (Month, Day, Year): JULY 30, 1999
3. Time of Death: 4:19 A.M.

4a. Facility Name (If not institution, give street and number): MONTGOMERY GENERAL HOSPITAL
4b. City, Town, or Location of Death: OLNEY
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 577-44-1584
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): OCT. 4, 1910
9. Birthplace (State or Foreign Country): NEBRASKA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: MONTGOMERY
10c. City, Town or Location: SILVER SPRING
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 3651 SOUTH LEISURE WORLD BLVD., APT.1D
10f. Zip Code: 20906-1718
10g. Citizen of What Country?: UNITED STATES OF AMERICA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: 1929-1949
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): NAVY
16b. Kind of Business/Industry: U.S. GOVERNMENT

17. Father's Name (First, Middle, Last): CHRIS NELSEN
18. Mother's Name (First, Middle, Maiden Surname): MARIE ANDERSON

19a. Informant's Name/Relationship (Type, Print): HELEN C. NELSEN (WIFE)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3651 SOUTH LEISURE WORLD BLVD., APT.1D SILVER SPRING MD 20906

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ARLINGTON NATIONAL CEMETERY
Date: AUG. 16, 1999
20c. Location - City or Town, State: ARLINGTON VIRGINIA

21. Signature of Funeral Service Licensee: ▶ James J. Schwartz.
22. Name and Address of Facility: HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVENUE SILVER SPRING MARYLAND 20904-2891

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. MYELODYSPLASTIC SYNDROME	1 year
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ G. Thaker, M.D.
29c. License number: D43430
29d. Date signed (Month, Day, Year): JULY, 31st, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): GAURANG THAKER, M.D. 18111 PRINCE PHILIP DR #212 OLNEY MD 20832

State Registrar

31. Date filed (Month, Day, Year): AUG 03 1999
32. Registrar's Signature: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25865

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Lamon Noppharat
2. Date of Death Month Day Year: August 3, 1999
3. Time of Death: 8:52am
4a. Facility Name *(If not institution, give street and number)*: Washington Adventist Hospital
4b. City, Town, or Location of Death: Takoma Park
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 220-15-1316
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 89 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Oct 18,1909
9. Birthplace *(State or Foreign Country)*: Thailand

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Hyattsville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3502 Hamilton Street
10f. Zip Code: 20782
10g. Citizen of What Country?: Thailand

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorcad
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Asian

15. Decadent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 0 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Nama *(First, Middle, Last)*: Unknown
18. Mother's Name *(First, Middle, Maiden Surname)*: Unknown

19a. Informant's Name/Relationship *(Type, Print)*: Payam D'Afflisio/ Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3502 Hamilton Street, Hyattsville, MD 20782

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from Stata 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other placa)*: Metropolitan Cematory — Date: Aug 4 1999
20c. Location - City or Town, State: Alexandria, VA

21. Signature of Funeral Service Licensee: ▶ Eric S. Scerbo
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd.W., Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart faxture. List only one cause on each line. — Approximete Interval Between Onset and Death

Immediete Cause (Final disease or condition resulting in deeth)
a. HYPOTENSION, AND RESPIRATORY FAILURE
Due to (or as a consequence of):
b. MYOCARDIAL INFARCTION
Sequantially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last
Due to (or as a consequenca of):
c. CORONARY ARTERY DISEASE
Due to (or as a consequenca of):
d.

Part ii. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

① Metabolic Acidosis
② Hypercholesterolemia
③ Renal Insufficiency

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of causa of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☑ Yes 2☐ No
26. Piece of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Rasidenca 8☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Placa of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) end manner as stated. 2☐ **Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to tha cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Mohammed A. Mannan MD
29c. License number: D24593
29d. Data signed *(Month, Day, Year)*: 8.3.99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MOHAMMED A. MANNAN M.D., 3331-TOLEDO TERRACE SUITE 206, HYATTSVILLE, MD 20782

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 04 1999
32. Registrar's Signature: ▶ Geneva B. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25866

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: William J. O'Brien, Jr.

2. Date of Death Month Dey Yaar: July 28, 1999

3. Time of Death: 6:40PM

4a. Facility Name *(If not institution, give street and number)*: 3620 Littledale Road, #214

4b. City, Town, or Location of Death: Kensington

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 018-20-2989

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 72 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Yeer)*: July 14, 1927

9. Birthplece *(State or Foreign Country)*: Massachusetts

Usuel Residence of Decedent

10e. Stete: Maryland

10b. County: Montgomery

10c. City, Town or Location: Kensington

10d. Inside City Limits: 1☒ Yas 2☐ No

10e. Street end Number: 3620 Littledale Road, #214

10f. Zip Code: 20895

10g. Citizen of Whet Country?: United States

11. Marital Status: 1☐ Never Merried 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yeer or Detes: World War II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Raca - American Indian, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): – ; Collega (1-4or 5+): 5+

16e. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Administrative Law Judge

16b. Kind of Business/Industry: U.S. Government

17. Fether's Nama *(First, Middle, Last)*: William J. O'Brien, Sr.

18. Mother's Name *(First, Middle, Meiden Surneme)*: Alice Marie Madden

19e. Informent's Name/Reletionship *(Type, Print)*: Quentin O'Brien Furlong/Daughter

19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 10130 Crestwood Road, Kensington, Maryland 20895

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Place of Disposition *(Nema of cemetery, crematory or other place)*: Blue Hills Cemetery

Dete: August 3, 1999

20c. Location - City or Town, State: Braintree, Massachusetts

21. Signature of Funeral Service Licensee: M00689

22. Name end Address of Feciliity: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. (Part I) Enter the diseese, or complications that caused tha deeth. Do not entar the mode of dying, such es cardiec or respiretory errest, shock, or heart feilure. List only one cause on each line.

Approximete Intervel Between Onsat and Death

tmmediate Ceuse (Finai diseese or condition resulting in deeth): e. Congestive Heart Failure — 2 years

Due to (or es a consequence of): Arteriosclerotic Heart Disease — 12 years

Sequentially tist conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest:

b. Due to (or es e consequence of):

c. Due to (or es e consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Diabetes, type II, Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yas 2☒ No

24b. Were autopsy findings eveileble prior to completion of causa of death? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Plece of Deeth *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residenca 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Dete of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, farm, street, fectory, offica building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifytng Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end msnner as steted. 2☐ **Medtcal Examtner:** On the basis of exemination and/or investigetion, in my opinion, deeth occurred et the time, dete end place, snd due to the cause(s) end menner steted.

29b. Signeture end titie of certifier: Jeremy V. Cooke MD

29c. Licanse number: D04662

29d. Data signed *(Month, Day, Year)*: July 29, 1999

30. Neme end address of person who completed cause of death (Item 23a) (Type, Print): Jeremy V. Cooke, M.D. 10400 Connecticut Avenue, Kensington, Maryland 20895

State Registrar

31. Dete filed *(Month, Day, Year)*: AUG 03 1999

32. Registrer's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

15+1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25867

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): David Bernhardt Ortman
2. Date of Death (Month, Day, Year): July 31, 1999
3. Time of Death: 1:50 pm
4a. Facility Name (If not institution, give street and number): 15000 W. Old Baltimore Rd.
4b. City, Town, or Location of Death: Boyds
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 132-10-5378
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 76 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): Jan 24, 1923
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Boyds
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 15000 W. Old Baltimore Rd.
10f. Zip Code: 20841
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Attorney
16b. Kind of Business/Industry: Private

17. Father's Name (First, Middle, Lest): Samuel J. Ortman
18. Mother's Name (First, Middle, Maiden Surname): Flora Grossman

19a. Informant's Name/Relationship (Type, Print): Elizabeth Farquhar/wife
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 15000 W. Old Baltimore Rd. Boyds, MD. 20841

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Judean Memorial
Date: 8/3
20c. Location - City or Town, State: Olney, MD.

21. Signature of Funeral Service Licensee: Michael L. Byrd
22. Name end Address of Facility: Takoma Funeral Home. 254 Carroll St. NW Washington, DC. 20012

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Finat disease or condition resulting in death)
e. Respiratory Arrest secondary to Lung Cancer
Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest
b. Hypertension, Hypercholesterolemia,
Due to (or as e consequence of):
c. Parkenson's Disease
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Gout

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residenca 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how Injury occurred
28e. Ptaca of Injury - At home, farm, street, factory, offica building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier: Charles B. Abrams
29c. License number: 6368 D.C.
29d. Date signed (Month, Day, Year): 8/2/99

30. Name and address of person who completed cause of death (item 23a) (Type, Print): Charles B. Abrams 2141 R St Wash D.C.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

24

State Registrar

31. Date filed (Month, Dey, Year): AUG 03 1999
32. Registrar's Signature: Irene G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25868

Certificate of Death Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARTHA S. OWENS
2. Date of Death Month / Day / Year: AUG. 3, 1999
3. Time of Death: 2149
4a. Facility Name *(If not institution, give street and number)*: SHADY GROVE ADVENTIST HOSPITAL
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 213-54-5012
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 61 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Apr 6,1938
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Md
10b. County: Montgomery
10c. City, Town or Location: Gaithersburg
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 9601 Stewarttown Rd,
10f. Zip Code: 20886
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11th Grade — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Bus Route Supervisor
16b. Kind of Business/Industry: Montg County Schls.

17. Father's Name *(First, Middle, Last)*: Nathan Waters
18. Mother's Name *(First, Middle, Maiden Surname)*: Dorothy Duvall

19a. Informant's Name/Relationship *(Type, Print)*: Kent Owens (Son)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 905 Lantern Hill Ct, Mt Airy, Md #21771

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Emory Grove Ch Cem.
Date: 8/7/99
20c. Location - City or Town, State: Gaithersburg, Md

21. Signature of Funeral Service Licensee: Ernest R. Snowden
22. Name and Address of Facility: Snowden Funeral Home P.A. 20850
246 N. Washington St, Rockville, Md

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Insulin dependent, Diabetes Mellites

Due to (or as a consequence of):
b. Hypertension

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Seizure Disorder

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Hypothyroidism, Right Femoral Nerve neuropathy
Sleep Apnea, Rheumatoid Arthritis
Renal Insufficiency

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Paul T. Wielebinski MD
29c. License number: D33719
29d. Date signed *(Month, Day, Year)*: August 4, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PAUL T. WIELEBINSKI, MD 18550 OFFICE PARK DRIVE, GAITHERSBURG, MD 20886

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 05 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

(B) 15

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25869

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JAMES LEROY ODEN

2. Date of Death Month: AUGUST Day: 4 Year: 1999

3. Time of Death: 11:10 AM

4a. Facility Name *(If not institution, give street and number)*: 10107 Howell Drive

4b. City, Town, or Location of Death: Upper Marlboro

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 215-38-5290

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 61 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 6, 1938

9. Birthplace *(State or Foreign Country)*:

Usual Residence of Decedent

10a. State: Maryland | 10b. County: Prince George's | 10c. City, Town or Location: Upper Marlboro | 10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 10107 Howell Drive | 10f. Zip Code: 20335 | 10g. Citizen of What Country?: USA

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): Unknown | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Disabled

16b. Kind of Business/Industry: Disabled

17. Father's Name *(First, Middle, Last)*: James Oden

16. Mother's Name *(First, Middle, Maiden Surname)*: Laura (unk) Oden

19a. Informant's Name/Relationship *(Type, Print)*: Thomas McCarty (PRD)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 12705 Country Lane Waldorf, MD 20601

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metropolitan Crematory | Date: 8-5-99

20c. Location - City or Town, State: Alexandria, VA

21. Signature of Funeral Service Licensee: John A. Eberwein M00173

22. Name and Address of Facility: J.H. Eberwein Mortuary 4433 White Pls La White Pla., MD 20695

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Multi organ Failure

Due to (or as a consequence of):
b. Lung Carcinoma

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DM II
COPD

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other *(Specify)*: Assisted Living

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)* | 26b. Time of Injury | 26c. Injury at Work? 1 ☐ Yes 2 ☐ No | 26d. Describe how injury occurred

26e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)* | 26f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D45630

29d. Date signed *(Month, Day, Year)*: 8/4/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Arnulfo Bonavente MD 6409 South Crain Hwy. Upper Marlboro, MD

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 06 1999

32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25870

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Joyce M. Oakes

2. Date of Death — Month: August; Day: 4,; Year: 1999

3. Time of Death: 5:21 p.m.

4a. Facility Name *(If not institution, give street and number)*: 6258 Belmont Circle

4b. City, Town, or Location of Death: Mount Airy

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 468-24-4236

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 70 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 8, 1929

9. Birthplace *(State or Foreign Country)*: Minnesota

Usual Residence of Decedent

10a. State: Maryland

10b. County: Carroll

10c. City, Town or Location: Mount Airy

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 6258 Belmont Circle

10f. Zip Code: 21771

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12); College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Travel Agent

16b. Kind of Business/Industry: self-employed

17. Father's Name *(First, Middle, Last)*: Brad Quackenbush

18. Mother's Name *(First, Middle, Maiden Surname)*: Florence Nichols

19a. Informant's Name/Relationship *(Type, Print)*: Barbara Williams/daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6258 Belmont Circle, Mt. Airy, Maryland 21771

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Hagerstown Crematory

Date: 8/5/99

20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Barry R. Sauerwald

22. Name and Address of Facility: Stauffer Funeral Homes, P.A.
8 East Ridgeville Blvd., Mt. Airy, MD 21771

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. hepatic failure — 4 d

Due to (or as a consequence of):
b. extensive breast carcinoma 5 mo

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: 31462S

29d. Date signed *(Month, Day, Year)*: Aug 5, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): [illegible] MD 501 W 7th St Frederick 21701

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 06 1999

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25871

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Kathleen Steele Paxson
2. Date of Death: Month July Day 31 Year 1999
3. Time of Death: 12:50 PM
4a. Facility Name (If not institution, give street and number): Wilson Health Care Center
4b. City, Town, or Location of Death: Gaithersburg
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 220 44 1826
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 96 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): August 13 1902
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Gaithersburg
10d. Inside City Limits: 1☐ Yes 2☒ No
10a. Street and Number: 301 Russell Ave.
10f. Zip Code: 20877
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher
16b. Kind of Business/Industry: Education

17. Father's Name (First, Middle, Last): William Shiner Steele
18. Mother's Name (First, Middle, Maiden Surname): Margaret Adelaide Chamblin

19a. Informant's Name/Relationship (Type, Print): Robert C.Steele/ Nephew
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 112 Cobassett St. Worchester Mass. 01604

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): George Washington Univ. Med. Ctr.
Date: 7/31/99
20c. Location - City or Town, State: Washington DC

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Columbias Mortuary Services PO Box 58007 Washington DC 20037

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Myocardial Infarction — Minutes
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hypothyroidism, Irritable bowel syndrome, Spinal Stenosis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D27301
29d. Date signed (Month, Day, Year): July 31, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DOUGLAS R. SHUMAKER, MD. 65 W. MONTGOMERY AVE. ROCKVILLE MD 20850

State Registrar

31. Date filed (Month, Day, Year): AUG 02 1999
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25872

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Louise Virginia Porter

2. Date of Death (Month, Day, Year): July 27 1999

3. Time of Death: 9:35 a.m.

4a. Facility Name (If not institution, give street and number): Northampton Manor Nursing Home

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 217-28-6920

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 93 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov 2 1905

9. Birthplace (State or Foreign Country): Washington DC

Usual Residence of Decedent

10a. State: MD

10b. County: Frederick

10c. City, Town or Location: Brunswick

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 22 N. Virginia Avenue

10f. Zip Code: 21716

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Florist

16b. Kind of Business/Industry: Brunswick Florist

17. Father's Name (First, Middle, Last): Chauncey Shepard Nicodemus

18. Mother's Name (First, Middle, Maiden Surname): Florence Thompson Nicodemus

19a. Informant's Name/Relationship (Type, Print): Bruce Porter, Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 526 West "B" St., Brunswick, MD 21716

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Park Heights Cemetery

Date: 7/30

20c. Location - City or Town, State: Brunswick, MD

21. Signature of Funeral Service Licensee: Barbara A. Williams

Barbara A. Williams, Owner

22. Name and Address of Facility: John T. Williams Funeral Home, 100 Petersville Road, Brunswick, MD 21716

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. arteriosclerotic cardiovascular disease Many years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: alzheimers disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D16675

29d. Date signed (Month, Day, Year): 7/28/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): WAYNE ALBAUGH BRUNSWICK, MD 21716

State Registrar

31. Date filed (Month, Day, Year): AUG 02 1999

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25873

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: WILTON PARISH

2. Date of Death Month: JULY Day: 24 Year: 1999

3. Time of Death: 2:30 PM

4a. Facility Name *(If not institution, give street and number)*: 27943 NANTICOKE RD

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 250-03-1727

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 84 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: MAY 2 1915

9. Birthplace *(State or Foreign Country)*: SOUTH CAROLINA

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: WICOMICO

10c. City, Town or Location: SALISBURY

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 27943 NANTICOKE RD

10f. Zip Code: 21801

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: FARMER

16b. Kind of Business/Industry: OWN FARM

17. Father's Name *(First, Middle, Last)*: THOMAS FRED PARISH

18. Mother's Name *(First, Middle, Maiden Surname)*: MAUDE WRIGHT

19a. Informant's Name/Relationship *(Type, Print)*: FRANCES P. PARISH - WIFE

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 27943 NANTICOKE RD. SALISBURY, MD 21801

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: PARSONS CEMETERY

Date: 7/29/99

20c. Location - City or Town, State: SALISBURY, MARYLAND

21. Signature of Funeral Service Licensee: ▶ B. Kent Phippin, CFSP

22. Name and Address of Facility: BOUNDS FUNERAL HOME, INC. 705 E. MAIN ST. SALISBURY, MD 21804

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Congestive Heart Failure — Years

Due to (or as a consequence of):
b. Renal Insufficiency — Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]

29c. License number: D34768

29d. Date signed *(Month, Day, Year)*: 7/27/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jeffrey Wieland, MD, PO Box 49, Salisbury, Md 21803

State Registrar

31. Date filed *(Month, Day, Year)*: JUL 28 1999

32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25874

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Julia Veronica Ramley
2. Data of Death (Month, Day, Year): August 2, 1999
3. Time of Death: 11:00 A.M.
4a. Facility Name (If not institution, give street and number): 226 Lee Street
4b. City, Town, or Location of Death: Gaithersburg
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 565-91-8624
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 55 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): July 1, 1944
9. Birthplace (State or Foreign Country): Indonesia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Gaithersburg
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 226 Lee Street
10f. Zip Code: 20877
10g. Citizen of What Country? Indonesia

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Asian

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Travel Agent
16b. Kind of Business/Industry: Travel

17. Father's Name (First, Middle, Last): Joseph Alexander Ramley
18. Mother's Name (First, Middle, Maiden Surname): Jane Marty Ong

19a. Informant's Name/Relationship (Type, Print): Daisy V. Saputra/Sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2821 West 167th Street, Torrance, CA. 90504

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Montecito Park Cemetery — Date: Aug. 8, 1999
20c. Location - City or Town, State: Loma Linda, California

21. Signature of Funeral Service Licensee: Michael D Gilbert
22. Name and Address of Facility: DeVol Funeral Home, 10 East Deer Park Dr., Gaithersburg, MD. 20877

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. METASTATIC CARCINOMA OF BREAST — 4 MONTHS
Due to (or as a consequence of):
b. BREAST CARCINOMA — 2 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Frank J. Mato, MD
29c. License number: 023630
29d. Data signed (Month, Day, Year): August 02, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Frank J. Mato, MD 16220 Frederick Rd #213 Gaithersburg, MD 20877

State Registrar

31. Data filed (Month, Day, Year): AUG 05 1999
32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25875

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ruth E. Reardon
2. Date of Death (Month, Day, Year): July 30, 1999
3. Time of Death: 6:25 PM
4a. Facility Name (If not institution, give street and number): Randolph Hills Nursing Center
4b. City, Town, or Location of Death: Wheaton
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 034-26-7636
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 20, 1908
9. Birthplace (State or Foreign Country): Massachusetts

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 4704 Oxbow Road
10f. Zip Code: 20852
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Salesperson
16b. Kind of Business/Industry: Retail

17. Father's Nema (First, Middle, Last): (Unavailable) Nyden
18. Mother's Name (First, Middle, Maiden Surname): Esther (Unavailable)

19a. Informent's Neme/Ralationship (Type, Print): Ruth Reardon Eaton (daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 261 Congressional Lane, #115, Rockville, MD 20852

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Parklawn Memorial Park
Data: 8-3-99
20c. Location - City or Town, Stete: Rockville, Maryland

21. Signeture of Funerel Service Licensee: Ellen H. Rapp
22. Name and Address of Facility: Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line.

Approximete Interval Between Onset and Deeth

Immedlete Cause (Finel disease or condition resulting in death)
a. Acute Renal Failure — 1 week
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Acute Tubular Necrosis
Due to (or as a consequence of):
c.
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier: Barry Rosenbaum
29c. License number: D 09834
29d. Date signed (Month, Day, Year): July 31, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Barry N. Rosenbaum, M. D., 3720 Farragut Avenue, Kensington, MD 20895

State Registrar

31. Date filed (Month, Day, Year): AUG 03 1999
32. Registrar's Signature: Jennie G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

99-4473-031
B.K.S

JAYMIE RODRIQUEZ
AMEND ITEMS: #23 PART I, 27 PER MEO G774 8-18-99 WR.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25876

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jaymie L. Rodriguez

2. Date of Death (Month, Day, Year): JULY 29, 1999

3. Time of Death: 2137 PM

4a. Facility Name (If not institution, give street and number): 1607 GRANDIN AVENUE

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 215-78-5518

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 34 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov.6,1964

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1607 Grandin Ave.

10f. Zip Code: 20851

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): Thomas M. Graham

18. Mother's Name (First, Middle, Meiden Surname): Elizabeth L. Swales

19a. Informant's Name/Relationship (Type, Print): Jose A. Rodriguez (Husband)

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 1607 Grandin Ave. Rockville, Md. 20851

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Chambers Crematory

Date: 8/5/99

20c. Location - City or Town, State: Riverdale, Md.

21. Signature of Funeral Service Licensee: Thomas S. Chambers # 670

22. Name and Address of Facility: Chambers Funeral Homes,P.A. 5801 Cleveland Ave. Riverdale, Md. 20737

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediete Cause (Finat disease or condition resulting in death)

a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially fist conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieled events resulting in death) Last

b.

Due to (or as e consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dennis J. Chute MD

29c. License number: O.C.M.E

29d. Date signed (Month, Day, Year): JULY 30, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dennis J. Chute, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Day, Year): AUG 03 1999

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth end Mental Hygiene.

Important: If item 27 le marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25877

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Josephine N. Ruhlman
2. Data of Death Month / Day / Year: July 31, 1999
3. Time of Death: 6:18 AM
4e. Facility Name *(If not institution, give street and number)*: Shady Grove Adventist Hospital
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 495-52-8584
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 82 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: January 11, 1917
9. Birthplace *(State or Foreign Country)*: Nebraska

Usual Residance of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 15308 Diamond Cove Terrace, Unit 6
10f. Zip Code: 20850
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Home Maker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Nathan Parsons
18. Mother's Name *(First, Middle, Maiden Surname)*: Cecelia DeBreaus

19e. Informant's Name/Relationship *(Type, Print)*: Kathleen Ruhlman /Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 15308 Diamond Cove Terrace, Unit 6, Rockville, MD 20850

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mount Olivet Cemetery — Date: August 3, 1999
20c. Location - City or Town, State: Kansas City, MO

21. Signature of Funeral Service Licensee: ▶ Howard A Causey #M00690
22. Name and Address of Facility: Muehlebach Funeral Home, 6800 Troost Avenue, Kansas City, Missouri 64131

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Atherosclerotic cardiovascular disease — years
Due to (or as a consequence of):
b. Left femoral neck fracture — one day

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*: July 30, 1999
28b. Time of Injury: 1730 hours
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: Fall at home
28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: Home, Kitchen
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: 15308 Diamond Cove Terrace, G, Rockville, MD 20850

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Patricia L. Tomsko, MD
29c. License number: D51916
29d. Date signed *(Month, Day, Year)*: July 31, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Patricia L. Tomsko, MD, PMB 348, 11140 Rockville Pike, Rockville, MD 20852

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 03 1999
32. Registrar's Signature: ▶ G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

4

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25878

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
Francis	Patrick	Ryan	July	30	1999	9:24AM

4e. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Manor Care Potomac	Potomac	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
207-01-2758	1☒ M 2☐ F	77 Yrs.					August 28, 1921	Pennsylvania

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
VA	Fairfax	McLean	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
8404 Parham Court	22102	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces? If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☒ Yes 2☐ No 1942 - 1946	1☐ Yes 2☒ No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	5+	Transportation Manager	Kodak Photographic Materials

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Patrick Thomas Ryan	Florence Mary Phillips

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Michael G. Ryan	8404 Parham Court McLean VA 22102

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)	Holy Sepulchre	8/3/99	Rochester, NY

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Robert Ramsey	Francis J. Collins Funeral Home, 500 University Blvd.W.Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. PARKINSONS	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ALZHEIMERS DEMENTIA

PARKINSON'S DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	H51280	7-30-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANUSH DADGAR, M.D.
13219 EXECUTIVE PARK TERRACE GERMANTOWN MD 20874

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
AUG 02 1999	Geneva G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

12+1

(12)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25879

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): VIOLET MAY ROSE
2. Date of Death (Month, Day, Year): August 5,1999
3. Time of Death: 3:20AM

4a. Facility Name (If not institution, give street and number): Civista Medical Center
4b. City, Town, or Location of Death: La Plata
4c. County of Death: Charles

Funeral Director

5. Social Security Number: 364-26-3220
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 84 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): October23,1914
9. Birthplace (State or Foreign Country): Michigan

Usual Residence of Decedent

10a. State: MD
10b. County: Charles
10c. City, Town or Location: Bryans Road
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 6975 Heather Drive
10f. Zip Code: 20616
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify: XX
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker/Musician
16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): George DeVries
18. Mother's Name (First, Middle, Maiden Surname): Lucille McDiarmid DeVries

19a. Informant's Name/Reletionship (Type, Print): Randolph Rose/Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6975 Heather Dr. Bryans Road,MD 20616

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stete 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Egelston Township Cem.
Date: 8/9/99
20c. Location - City or Town, State: Muskegon,MI.

21. Signature of Funeral Service Licensee: David C. Echols M00945
22. Name and Address of Facility: AREHART-ECHOLS FUNERAL HOME P.A. P.O. BOX 567 LA PLATA,MD 20646

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)
a. Urosepsis
Due to (or as a consequence of):
b. Urinary Tract infection
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Wes cese referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, dete end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: Michael C Leatherwood, MD
29c. License number: D-21031
29d. Date signed (Month, Day, Year): 8/5/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael A. Leatherwood,MD 12070 Old Line Center Suite 202 Waldorf,Maryland20602

State Registrar

31. Date filed (Month, Day, Year): AUG 06 1999
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

permit. Pagas 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Violet Rose

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25880

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Charlotte Frances REEDER
2. Date of Death (Month, Day, Year): July 28, 1999
3. Time of Death: 4:05 AM
4a. Facility Name (If not institution, give street and number): Citizens Nursing Home
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 212-38-9614
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): Sept. 30, 1908
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1900 Rosemont Avenue
10f. Zip Code: 21702
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Hiram REMSBURG
18. Mother's Name (First, Middle, Meiden Surname): Emma YOUNG

19a. Informant's Neme/Relationship (Type, Print): Mr. Clarence R. Reeder, Son
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 117 Kline Blvd., Frederick, Maryland 21701

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Lutheran Cemetery, July 31, 1999 | Date
20c. Location - City or Town, State: Middletown, Maryland

21. Signature of Funeral Service Licensee: Richard C. Basford #00021
22. Name and Address of Facility: Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick, Md. 21701

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final diseese or condition resulting in death): a. CVA — 3mos

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner steted.
29b. Signature and title of certifier: Robert L. Kaufman MD
29c. License number: D-13977
29d. Date signed (Month, Day, Year): July 28, 1999

30. Name and address of parson who completed cause of death (Item 23a) (Type, Print): Robert L Kaufman MD 300 W 9th St., Frederick MD 21701

State Registrar

31. Date filed (Month, Day, Year): JUL 30 1999
32. Registrar's Signature: Geneva G. Sparks

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25881

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Barbara C. Richardson
2. Date of Death (Month, Day, Year): July 22, 1999
3. Time of Death: 11:00 PM
4a. Facility Name *(If not Institution, give street and number)*: Salisbury Center: Genesis ElderCare
4b. City, Town, or Location of Death: Salisbury, MD
4c. County of Death: Wicomico

Funeral Director

5. Social Security Number: 212-01-9656
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 85 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 7-19-1914
9. Birthplace *(State or Foreign Country)*: Md.

Usual Residence of Decedent

10a. State: Md.
10b. County: Wicomico
10c. City, Town or Location: Delmar
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 9309 Colonial Mill Dr.
10f. Zip Code: 21875
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 — College (1-4 or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Seamstress
16b. Kind of Business/Industry: Garment Co.

17. Father's Name *(First, Middle, Last)*: Alexander Close
18. Mother's Name *(First, Middle, Maiden Surname)*: Minnie Brode

19a. Informant's Name/Relationship *(Type, Print)*: Barbara A. Wiggs, Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9309 Colonial Mill Dr. Delmar, Md. 21875

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Beachwood Cemetery — Date: 7-27-99
20c. Location - City or Town, State: Princess Anne, Md.

21. Signature of Funeral Service Licensee: William M. Short
22. Name and Address of Facility: Short Funeral Home, Inc. 13 E. Grove St. Delmar, De. 19940

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Lymphoma — Due to (or as a consequence of): — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. — Due to (or as a consequence of):
c. — Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D 29349
29d. Date signed *(Month, Day, Year)*: 7/23/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William H. Robins, M.D. 1104 Healthway Dr., Salisbury, MD 21804

State Registrar

31. Date filed *(Month, Day, Year)*: JUL 27 1999
32. Registrar's Signature: Denise G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25882

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): SAUL SHAFRITZ
2. Date of Death (Month, Day, Year): AUGUST 1, 1999
3. Time of Death: 6:00 AM

4a. Facility Name (If not institution, give street and number): WASHINGTON ADVENTIST HOSPITAL
4b. City, Town, or Location of Death: TAKOMA PARK
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 577-09-5169
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): NOV. 2, 1911
9. Birthplace (State or Foreign Country): PENNSYLVANIA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: MONTGOMERY
10c. City, Town or Location: SILVER SPRING
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 15028 HASLEMERE COURT
10f. Zip Code: 20906
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): PODIATRIST
16b. Kind of Business/Industry: MEDICAL

17. Father's Name (First, Middle, Last): NATHAN SHAFRITZ
18. Mother's Name (First, Middle, Maiden Surname): REBECCA (UNKNOWN)

19a. Informant's Name/Relationship (Type, Print): STEPHEN PAUL SHAFRITZ (SON)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10933 AMHERST AVENUE - WHEATON, MARYLAND 20902

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): KING DAVID MEM. GDNS.
Date: 8/4/99
20c. Location - City or Town, State: FALLS CHURCH, VIRGINIA

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE-ROCKVILLE, MARYLAND 20852

Physician /Medical Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. acute myocardial infarction — 3 weeks

Due to (or as a consequence of):
b. atherosclerotic cardiovascular disease — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
congestive heart failure, renal failure, respiratory failure, diabetes mellitus, hypertension

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Roger Leonard MD
29c. License number: D28791
29d. Date signed (Month, Day, Year): 8/1/99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Roger L. Leonard MD, 6116 Executive Blvd, Rockville MD 20852

State Registrar

31. Date filed (Month, Day, Year): AUG 03 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25883

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MIRA SHEVELEVICH
2. Date of Death (Month, Day, Year): AUGUST 1, 1999
3. Time of Death: 12:05 P.M.
4a. Facility Name (If not institution, give street and number): Suburban Hospital
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 219-43-5987
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 25, 1917
9. Birthplace (State or Foreign Country): Soviet Union

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 6121 Montrose Road
10f. Zip Code: 20852
10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 Years | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Boruh Lyahov
18. Mother's Name (First, Middle, Maiden Surname): Sosha Leikina

19a. Informant's Name/Relationship (Type, Print): Alla Shevelevich-Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10625 Tuppence Court, Rockville, Maryland 20850

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Judean Memorial Gardens | Date: 8/3/99
20c. Location - City or Town, State: Olney, Maryland

21. Signature of Funeral Service Licensee: ▶ Donald C. Stottlemyer
22. Name and Address of Facility: Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike, Rockville, Maryland 20852

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respirelory errest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Finat disease or condition resulting in death): a. Pneumonia — 8 days
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last:
b.
Due to (or es a consequence of):
c.
Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Katharine R. Lillie MD
29c. License number: D53244
29d. Date signed (Month, Day, Year): August 3, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Katharine R. Lillie, MD 11140 Rockville Pike #348, Rockville, MD 20852

State Registrar

31. Date filed (Month, Day, Year): AUG 04 1999
32. Registrar's Signature: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Shevelevich, Mira 8-1-99 12:05 PM JY

99-4532-031
crn
Justine V. Schrader

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25884

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JUSTINE V. SHRADER
2. Date of Death (Month, Day, Year): August 02, 1999
3. Time of Death: 10:17 A.M.
4a. Facility Name (If not institution, give street and number): 13104 Englewood Street
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-52-9742
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 59 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MARCH 3, 1940
9. Birthplace (State or Foreign Country): WASHINGTON, DC

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: MONTGOMERY
10c. City, Town or Location: SILVER SPRING
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 13104 ENGLEWOOD STREET
10f. Zip Code: 20904
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: HOME

17. Father's Name (First, Middle, Last): JULIUS F. SIMON
18. Mother's Name (First, Middle, Maiden Surname): VIRCIE LIEWALD

19a. Informant's Name/Relationship (Type, Print): TERESA McCAUSLAND/DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 17501 CHEROKEE LANE OLNEY, MD 20832

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): FT. LINCOLN CREMATORY
Date: 08/05/99
20c. Location - City or Town, State: BRENTWOOD, MD

21. Signature of Funeral Service Licensee: ▶ Anthony D. DiMarco
22. Name and Address of Facility: HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVENUE SILVER SPRING, MD20904

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

(b)

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Gunshot Wound of Head
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☒ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year): UNK
28b. Time of Injury: UNK M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: Subject Shot self
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): AT HOME
28f. Location (Street and Number or Rural Route Number, City or Town, State): 13104 Englewood St. 20904

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Jonathon Locke, MD
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): August 03, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jonathon Locke, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): AUG 06 1999
32. Registrar's Signature: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

99-4531-031
crn
Tyrone Howard Schrader

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25885

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): TYRONE HOWARD SHRADER, SR.
2. Date of Death (Month, Day, Year): August 02, 1999
3. Time of Death: 10:17 A.M.
4a. Facility Name (If not institution, give street and number): 13104 Englewood Street
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-52-4473
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 60 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): AUG. 6, 1938
9. Birthplace (State or Foreign Country): WEST VIRGINIA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: MONTGOMERY
10c. City, Town or Location: SILVER SPRING
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 13104 ENGLEWOOD STREET
10f. Zip Code: 20904
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): AUTOMOBILE BODY REPAIR
16b. Kind of Business/Industry: OWN BUSINESS

17. Father's Name (First, Middle, Last): STEWART L. SHRADER
18. Mother's Name (First, Middle, Maiden Surname): VIRGINIA SHRADER

19a. Informant's Name/Relationship (Type, Print): TERESA McCAUSLAND (DAUGHTER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 17501 CHEROKEE LANE OLNEY, MD 20832

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): FT. LINCOLN CREMATORY
Date: 08/05/99
20c. Location - City or Town, State: BRENTWOOD, MD

21. Signature of Funeral Service Licensee: Anthony S. DeMyer
22. Name and Address of Facility: HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVE SILVER SPRING, MD 20904

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Gunshot Wound to Head
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated eventa resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [X] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year): UNK
28b. Time of Injury: UNK M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: Subject Shot
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): AT HOME
28f. Location (Street and Number or Rural Route Number, City or Town, State): 13104 Englewood St. 20904

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] MD
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): August 03, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JULIAN LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

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State Registrar

31. Date filed (Month, Day, Year): AUG 06 1999
32. Registrar's Signature: Jeanne G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25886

Amend #23b & #23a-pt2,8/10/99,BMW,Montg.Co

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
DONNELL	DEXTER	SMITH	AUGUST 04 1999	1220

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SHADY GROVE ADVENTIST HOSPITAL	ROCKVILLE	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
267-24-5230	1☒ M 2☐ F	72 Yrs.			May 23, 1927	Minnesota

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Montgomery Village	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
20243 Maple Leaf Court	20886	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Merried 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grede completed)		16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	Collega (1-4or 5+)		
	4	Foreign Service Officer	Federal Government

17. Father's Name (First, Middle, Last)	18. Mother's Nama (First, Middle, Meiden Surneme)
Donnell Dillman Smith	Vera Corbly Young

19a. Informant's Name/Ralationship (Type, Print)	19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Code)
Elfriede Smith (Wife)	20243 Maple Leaf Court, Montgomery Village, MD 20886

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other piece)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Metropolitan Crematory	8/5/99	Alexandria, Virginia

21. Signature of Funeral Service Licensee: Robert M. DeVol

22. Name and Address of Facility: DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not entar the mode of dying, such es cardiac or respiratory errest, ahock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Ceuse (Final disease or condition resulting in death)	e. MULTI SYSTEM ORGAN FAILURE	3 DAYS
Dua to (or as a consequance of):	b. JEJUNAL VOLVULUS WITH PERFORATION	6 DAYS
Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaase or injury that initiated events rasulting in death) Last	c. GANGRENE of RIGHT LEG	4 DAYS
Due to (or as a consequenca of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause given in Part I.

Parkinson's Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☑ No	1☐ Yes 2☑ No

25. Was casa raferred to medical examiner?	26. Piaca of Death (Check only one)	
1☐ Yes 2☑ No	Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Dey Year)	28b. Tima of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Panding Investigation 6☐ Could not be determined		M	1☐ Yas 2☐ No	

28e. Placa of Injury - At home, farm, street, factory, offica building, atc. (Specify)	28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Cartifier (Check only one): 1☑ **Certifying Physician**: To tha best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at tha tima, data and place, and dua to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Dete signed (Month, Day, Year)
MD.	D 53864	8/4/99

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

Richard Silva, MD 9715 Medical Center Drive #105, Rockville, MD 20850

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
AUG 05 1999	Geneva G. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

15

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25887

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Hazel M. Smith
2. Date of Death (Month, Day, Year): August 4, 1999
3. Time of Death: 9:15AM
4a. Facility Name (If not Institution, give street and number): Wilson Health Care
4b. City, Town, or Location of Death: Gaithersburg
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-01-0759
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JULY 30, 1910
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: MONTGOMERY
10c. City, Town or Location: GAITHERSBURG
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 211 RUSSELL AVENUE
10f. Zip Code: 20877
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SECRETARY
16b. Kind of Business/Industry: BANKING

17. Father's Name (First, Middle, Last): WARREN SMITH
18. Mother's Name (First, Middle, Maiden Surname): MAMIE EDWARDS

19a. Informant's Name/Relationship (Type, Print): CAROL S. RUSSELL/NIECE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 337 DEAN DRIVE ROCKVILLE, MD 20851

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): GEORGE WASHINGTON | Date: 08/07/99
20c. Location - City or Town, State: ADELPHI, MD

21. Signature of Funeral Service Licensee: Anthony S. DiMeo
22. Name and Address of Facility: HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVE SILVER SPRING, MD 20904

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one causa on aach lina.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in daath) a.	cerebrovascular accident	3 weeks
Due to (or as a consequence of): b.	atherosclerosis	years
Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was casa raferred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Panding Investigation 6☐ Could not be datermined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John R. Melnick MD
29c. License number: D19294
29d. Date signed (Month, Day, Year): August 4, 1999

30. Name and address of person who completed causa of daath (Item 23a) (Type, Print): JOHN MELNICK 911 RUSSELL AVE GAITHERSBURG, Md. 20879

State Registrar

31. Date filed (Month, Day, Year): AUG 06 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25888

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mardie Sylvester Stafford
2. Date of Death (Month, Day, Year): July 31, 1999
3. Time of Death: 9:15pm
4a. Facility Name (If not institution, give street and number): Montgomery Village Nursing & Rehab.
4b. City, Town, or Location of Death: Montgomery Village
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 422-32-8105
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 88 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 15, 1910
9. Birthplace (State or Foreign Country): Alabama

Usual Residence of Decedent

10a. State: Md.
10b. County: Frederick
10c. City, Town or Location: Monrovia
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3125 Will-Mil Terrace
10f. Zip Code: 21770
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Resident Manager
16b. Kind of Business/Industry: Rental Property

17. Father's Name (First, Middle, Last): Roe Dolphus Banks
18. Mother's Name (First, Middle, Maiden Surname): Emma Elizabeth Price

19a. Informant's Name/Relationship (Type, Print): Kenneth Stafford (Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3125 Will-Mil Terr. Monrovia, Md. 21770

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Parlawn Memorial Park
Date: Aug. 4, 1999
20c. Location - City or Town, State: Rockville, Md.

21. Signature of Funeral Service Licensee: ▶ Curtis E. Day
22. Name and Address of Facility: DeVol Funeral Home 10 East Deer Park Dr. Gaithersburg, Md. 20877

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Arrhythamia — Minutes

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Dehydration, Pressure sore Malnutrition

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ G Chablani
29c. License number: D42578
29d. Date signed (Month, Day, Year): August 02, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Gul Chablani M.D. 11119 Rockville Pike #401 Rockville, Md. 20852

State Registrar

31. Date filed (Month, Day, Year): AUG 03 1999
32. Registrar's Signature: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25889.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): George Standish, Jr.
2. Date of Death (Month, Day, Year): August 1, 1999
3. Time of Death: 5:06A.

4a. Facility Name (If not institution, give street and number): Laurel Regional Hospital
4b. City, Town, or Location of Death: Laurel
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 199-20-3280
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 70 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 20, 1928
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Beltsville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 4214 Wicomico Avenue
10f. Zip Code: 20705
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1951-1953
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 3
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Supervisor
16b. Kind of Business/Industry: Washington Suburban Sanitary Commission

17. Father's Name (First, Middle, Last): George Standish, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Margaret P. Buday

19a. Informant's Name/Relationship (Type, Print): Ellen L. Standish (wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): same as #10

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): St. Mary's Cemetery
Date: 8/5/1999
20c. Location - City or Town, State: Masontown, Pennsylvania

21. Signature of Funeral Service Licensee: Donald V. Borgwardt
22. Name and Address of Facility: Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardiac arrest — minutes

Due to (or as a consequence of):
b. Coronary artery disease — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Renal failure — months

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Timothy P. McClain MD
29c. License number: D39532
29d. Date signed (Month, Day, Year): 8/3/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 321 Prince George St. Laurel MD 20707 Timothy P. McClain

State Registrar

31. Date filed (Month, Day, Year): AUG 03 1999
32. Registrar's Signature: Rebecca G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Amended line 5
FCHD KS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25890

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Paul Luther Stine, Jr.

2. Date of Death (Month, Day, Year): July 29, 1999

3. Time of Death: 2018

4a. Facility Name (If not institution, give street and number): 4004 Olive School Road

4b. City, Town, or Location of Death: Knoxville

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: ~~212-38-7502~~ 215-74-5601

6. Sex: XX 1 M 2 F

7. Age (In yrs. last birthday): 60 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 20, 1938

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland | 10b. County: Frederick | 10c. City, Town or Location: Knoxville | 10d. Inside City Limits: 1 Yes 2 XX No

10e. Street and Number: 4004 Olive School Road | 10f. Zip Code: 21758 | 10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 X Never Married 2 Married 3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Farmer

16b. Kind of Business/Industry: Farming

17. Father's Name (First, Middle, Last): Paul Luther Stine, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Julia Eleanor Dryden

19a. Informant's Name/Relationship (Type, Print): Alice Jean Stine/Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4004 Olive School Rd., Knoxville, Md. 21758

20a. Method of Disposition: 1 X Burial 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): St. Mark's Cemetery | Date: Aug. 3, 1999 | 20c. Location - City or Town, State: Petersville, Maryland

21. Signature of Funeral Service Licensee: Richard C.C. Basford M00021

22. Name and Address of Facility: Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick, Md. 21701

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Sudden Cardiac Death	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Aortic Stenosis	3 yrs
	Due to (or as a consequence of):	
	c. Bacterial Endocarditis	4 yrs
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 X No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 X No

25. Was case referred to medical examiner? 1 Yes 2 X No

26. Place of Death (Check only one): Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA | Other: 4 Nursing Home 5 X Residence 6 Other (Specify)

27. Manner of Death: 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year): N/A

28b. Time of Injury: N/A M

28c. Injury at Work? N/A 1 Yes 2 No

28d. Describe how injury occurred: N/A

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): N/A

28f. Location (Street and Number or Rural Route Number, City or Town, State): N/A

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) end manner as stated. 2 **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end manner atated.

29b. Signature and title of certifier: MD

29c. License number: D47397

29d. Date signed (Month, Day, Year): July 30, 1999

30. Neme and address of person who completed cause of death (Item 23e) (Type, Print): Michael W. Levergie MD 310 W. 9th St. Frederick MD 21701

State Registrar

31. Date filed (Month, Day, Year): AUG 02 1999

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25891

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Barbara Elizabeth SEEGER
2. Date of Death (Month, Day, Year): July 29, 1999
3. Time of Death: 4:25 PM
4a. Facility Name (If not Institution, give street and number): Frederick Health Care Center
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 213-24-9805
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 94 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): Feb. 11, 1905
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 600 Magnolia Avenue
10f. Zip Code: 21701
10g. Citizen of What Country? U.S.A.

11. Maritel Stetus: 1☐ Never Merried 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Rece - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 | College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Operator
16b. Kind of Business/Industry: Telephone Company

17. Father's Neme (First, Middle, Last): Harry LOCHNER
18. Mother's Name (First, Middle, Maiden Surneme): Lydia HALLER

19a. Informent's Neme/Reletionship (Type, Print): Mrs. Lois S. Filby, DAUGHTER
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 5535 Etzler Road, Frederick, Maryland 21702

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other piece): Mount Olivet Cemetery, July 31, 1999 | Date
20c. Location - City or Town, Stete: Frederick, Maryland

21. Signeture of Funeral Service Licensee: ▶ Richard E. Bray M00255
22. Name end Address of Facility: Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick, Md. 21701

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one cause on eech line. | Approximete Interval Between Onset and Death

Immediate Cause (Finel diseese or condition resulting in death)
a. Gangrene Foot BL
Due to (or es a consequence of):
b. Myelodysplasia
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Last
Due to (or es a consequence of):
c.
Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Coronary artery disease
Osteoporosis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No N/A

25. Wes case referred to medicat examiner? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) end menner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) and menner stated.
29b. Signetura and title of certifier: ▶ MD
29c. License number: D51643
29d. Date signed (Month, Dey, Yeer): July 30, 1999
30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Hiren. N. Shah 170 Thomas Johnson Drive # 100 Frederick MD 21702

State Registrar

31. Date filed (Month, Day, Year): AUG 02 1999
32. Registrar's Signeture: ▶ G. Spach

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25892

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)				2. Date of Death Month Day Year	3. Time of Death
ALBERT	RICHARDSON	SAPP	SR.	July 31, 1999	2:30 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
22745 Capitola Road	Tyaskin	Wicomico

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	If Under 1 Year Days	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
337-14-4709	1☒ M 2☐ F	79 Yrs.					April 27, 1920	Georgia

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Michigan	Wayne	Detroit	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
16567 Cherrylawn	48221	USA

11. Marital Status	12. Was Decedent Ever In U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8	-	Milkman	Dairy Industry

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Harry R. Sapp	Geneva M. Brown

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Charlotta A. Sapp-Price-Daughter	22745 Capitola Rd., Tyaskin, MD 21865

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Salisbury Crematory	8/2/99	Salisbury, MD

21. Signature of Funeral Service Licensee		22. Name and Address of Facility
▶ David A. Thompson	M01051	Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. aspiration pneumonia

Due to (or as a consequence of):
Parkinson's Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia

Type II Diabetes mellitus

Arteriosclerotic cardiovascular disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ D K H	D0051232	8.2.99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
10445 Ocean City Blvd Berlin MD 21811 David K. Hoshino M.D

3

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
AUG 02 1999	Donna G Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25893

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Heyward Allen Shepperd
2. Date of Death Month / Day / Year: August 6 1999
3. Time of Death: 9:15 PM
4a. Facility Name *(If not Institution, give street and number)*: Mariner Health of Forest Hill
4b. City, Town, or Location of Death: Forest Hill, MD
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 218-22-1545
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 70 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Oct. 30, 1928
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: White Hall
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 19810 Graystone Rd.
10f. Zip Code: 21161
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: Korea
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Maintanence
16b. Kind of Business/Industry: Baltimore Co. Board of Education
17. Father's Name *(First, Middle, Last)*: Charles P. Shepperd
18. Mother's Name *(First, Middle, Maiden Surname)*: Olivia Meredith
19a. Informant's Name/Relationship *(Type, Print)*: David C. Shepperd/Nephew
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4416 Fox Chase Lane, White Hall, MD 21161
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: West Liberty Cemetery — Date: Aug. 9, 1999
20c. Location - City or Town, State: White Hall, MD
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: J.J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA 17349

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Emphysema — 7 24 year

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of Certifier: [signature]
29c. License number: D28 339
29d. Date signed *(Month, Day, Year)*: August 8, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): CINDA PHELPS at 101 E Wheel Road Bel Air MD 21015

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 16 1999
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

99-4458-510
DONALD E. TOMS
ASP

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25894

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Donald E. Toms, Sr.
2. Dete of Deeth: Month JULY; Dey 29; Year 1999
3. Time of Death: 3:34 A
4e. Facility Neme (If not institution, give street and number): MARYLAND SHOCK TRAUMA
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Deeth:

Funeral Director

5. Social Security Number: 217-50-0364
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthday): 50 Yrs.
If Under 1 Year: Months; Days
If Under 24 Hrs.: Hours; Min.
8. Date of Birth (Month, Dey, Year): August 24, 1948
9. Birthplace (Stete or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Carroll
10c. City, Town or Location: Taylorsville
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 2424 Sams Creek Rd.
10f. Zip Code: 21157
10g. Citizen of What Country?: United States
11. Meritel Stetus: 1☐Never Married 2☐Merried 3☐Widowed 4☒Divorced
12. Was Decedent Ever in U.S. Armed Forces? ☒☒Yes 2☐No If Yes, Give Year or Dates: 1965-1969
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, apecify Cuben, Mexican, Puerto Rican, etc.): 1☐Yes 2☒No Specify:
14. Rece - American Indian, Black, White, etc. Specify: White
15. Decedent'a Education (Specify only highest grade completed): Elementery/Secondery (0-12): 11th; College (1-4or 5+):
16a. Decedent'a Uaual Occupation (Give kind of work done during most of working life. DO NOT use retired): Carpenter
16b. Kind of Business/Industry: Patrick Construction
17. Father'a Neme (First, Middle, Last): Elmer Toms
18. Mother's Name (First, Middle, Maiden Surneme): Aldena E. Engle
19a. Informent's Neme/Reletionship (Type, Print): Donald E. Toms, Jr. (Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2424 Sams Creek Rd. Taylorsville, MD 21157
20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from Stete 4☐Donetion 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other piece): Garrison Forest Veterans
Dete: 8/2/99
20c. Location - City or Town, Stete: Owings Mills, MD
21. Signeture of Funeral Service Licensee:
22. Neme end Address of Feciility: Burrier-Queen Funeral Directors, P.A. 1212 West Old Liberty Rd. Winfield, MD 21784

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heert failure. List *only one* cause on eech line.

Approximate Interval Between Onset and Deeth

Immediete Cause (Finel diseese or condition resulting in deeth): a. Multiple Injuries
Due to (or as a consequence of):
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in death) Last
b.
Due to (or es a consequence of):
c.
Due to (or es a consequence of):
d.

Part II. **Other signifi:cant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Arteriosclerotic Cardiovascular Disease

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24e. Wes an autopsy performed? 1☒Yes 2☐No

24b. Were autopsy findings eveilable prior to completion of cause of deeth? 1☒Yes 2☐No

25. Wes case referred to medical examiner? 1☒Yes 2☐No

26. Place of Death (Check only one): Hospitel: 1☐Inpatient 2☐ER/Outpatient 3☒DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☐Neturel 2☒Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined

28a. Dete of Injury (Month, Dey Year): 7/29/99
28b. Time of Injury: 0050 M
28c. Injury at Work? 1☐Yes 2☒No
28d. Describe how injury occurred: driver in auto accident
28e. Place of Injury - At home, ferm, streat, factory, office building, etc. (Specify): Street
28f. Location (Street and Number or Rurel Route Number, City or Town, Stete): 5B Hanover Pike

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29e. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and menner as stated. 2☒ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end pleca, and due to the cause(s) and menner steted.

29b. Signature and title of certifier:
29c. License number: O.C.M.E
29d. Dete signed (Month, Day, Year): JULY 29,1999

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): J. Hatton Locke MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Day, Year): JUL 30 1999
32. Registrar's Signature: Jenna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25895

Certificate of Death Reg. No.

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Linda L. Thornton
2. Dete of Deeth: Month August Dey 1 Year 1999
3. Time of Death: 4:00am
4e. Facility Neme *(If not institution, give street end number)*: 3923 Colchester Road
4b. City, Town, or Location of Deeth: Baltimore
4c. County of Deeth:

Funeral Director

5. Social Security Number: 213-76-3919
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 41 Yrs. — If Under 1 Yeer: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Dey, Year)*: Aug 22 1957
9. Birthplece *(Stete or Foreign Country)*: Md

Usuel Residence of Decedent

10e. State: Md
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3923 Colchester Road
10f. Zip Code: 21229
10g. Citizen of Whet Country?: USA

11. Meritel Stetus: 1☐ Never Merried 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces?: 1☐ Yes 2☒ No If Yes, Give Year or Detes:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indien, Bleck, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondery (0-12): 12 — College (1-4or 5+):
16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: photographer
16b. Kind of Business/Industry: photography

17. Fether's Neme *(First, Middle, Last)*: Richard A. Pratt
18. Mother's Neme *(First, Middle, Maiden Surneme)*: Goldie M. Wilson

19a. Informant's Name/Reletionship *(Type, Print)*: Clifton E. Thornton Sr. (spouse)
19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 3923 Colchester Rd., Baltimore, Md 21229

20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Carroll Cremation Serv. Dete: 8-4-99
20c. Location - City or Town, Stete: Hampstead, Md

21. Signeture of Funerel Service Licensee: ▶ Brian L. Haight
22. Neme end Address of Fecility: Haight Funeral Home & Chapel P.O. Box 195 Sykesville, Md 21784

Physician /Medical Examiner

23e. Pert I. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert failure. List only one ceuse on each line.

Approximete Interval Between Onset end Deeth

Immediate Ceuse (Finel diseese or condition resulting in deeth)
e. Metastatic lung cancer — 11 mos.
Due to (or es e consequence of):

Sequentially list conditions, if eny, leeding to immediete ceuse. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest
b. Due to (or es e consequence of):
c. Due to (or es e consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death?: 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24e. Wes en eutopsy performed?: 1☐ Yes 2☑ No
24b. Were autopsy findings evelleble prior to completion of cause of deeth?: 1☐ Yes 2☑ No

25. Was case referred to medical exeminer?: 1☐ Yes 2☑ No
26. Place of Death *(Check only one)*: Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☑ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28e. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury
28c. Injury at Work?: 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred et the time, dete end piece, and due to the cause(s) end manner es steted. 2☐ **Medicel Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end menner stated.

29b. Signeture and title of certifier: ▶ MD
29c. License number: D40850
29d. Dete signed *(Month, Dey, Year)*: August 2, 1999

30. Neme end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print): YVONNE OTTAVIANO MD 900 Caton Ave Baltimore Md 21229

State Registrar

31. Dete filed *(Month, Dey, Year)*: AUG 0 3 1999
32. Registrer's Signeture: Geneva G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25896

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: SHIRLEY ANN TOPPER
2. Deta of Daeth — Month: July; Dey: 27; Yeer: 1999
3. Time of Death: 1500
4a Facility Neme *(If not institution, giva street end number)*: 100 Creekside Drive, Apartment 9
4b. City, Town, or Location of Death: Emmitsburg
4c. County of Death: Frederick County

Funeral Director

5. Social Security Number: 216-60-8764
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 47 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Jan. 11, 1952
9. Birthplece *(State or Foreign Country)*: Pennsylvania

Usuel Residence of Decedant

10a. State: Maryland
10b. County: Frederick County
10c. City, Town or Location: Emmitsburg
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 100 Creekside Drive, Apartment 9
10f. Zip Code: 21727
10g. Citizen of Whet Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Yaar or Detes:
13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuben, Mexican, Puarto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Reca - American Indien, Black, Whita, atc. *Specify:* White

15. Decedent's Education *(Specify only highast grada completed)*: Elementery/Secondary (0-12): 12; College (1-4or 5+): 0
16a. Decedent's Usuel Occupetion *(Giva kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Fether's Neme *(First, Middle, Last)*: William G. Sheeley
18. Mother's Name *(First, Middle, Malden Surneme)*: Ruby N. Glass

19a. Informent's Neme/Relationship *(Type, Print)*: Angela Topper / daughter
19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 100 Creekside Drive, Apt. 9 Emmitsburg, MD 21727

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Ramoval from Stete 4☐ Donetion 5☐ Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Smithburg Crematory — Date: July 29 1999
20c. Location - City or Town, Stete: Smithburg, Maryland

21. Signature of Funeral Service Licensee: John M. Skiles M00534
22. Neme end Address of Facility: Skiles Funeral Home, 210 West Main Street, Emmitsburg, MD 21727

Physician /Medical Examiner

23a. Pert I. Enter tha disease, or complications that caused the death. Do not enter tha moda of dying, such as cardiac or raspiretory errest, shock, or heert feilure. List only one cause on aach line.

Approximete Interval Batween Onset and Death

Immediete Ceuse (Finai disaesa or condition resulting in death)
e. Head Injury — Immediate
Due to (or es e consequence of):
b. Type 2 Diabetes. — Years
Sequentiaily iist conditions, if any, leeding to immadiete cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last
Due to (or as e consaquenca of):
c. Anemia — years
Due to (or as e consaquenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause given in Part I.: BiPolar Disorder

23b. Did tobacco use contributa to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings eveilable prior to compiation of cause of death? 1☐ Yas 2☐ No

25. Wes case referred to medical exeminer? 1☒ Yas 2☐ No
26. Piece of Deeth *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residenca 6☐ Other *(Specify)*

27. Menner of Death: 1☐ Neturei 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Dete of Injury *(Month, Dey Year)*: July 29, 1999
28b. Tima of Injury: 3:00 P M
28c. Injury et Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: Head Struck Table
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*: home
28f. Location *(Street and Number or Rurel Route Number, City or Town, Stete)*: 100 Creekside, Emmitsburg.

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete and piece, and due to the cause(s) and manner es stated. 2☒ **Medical Examiner:** On the basis of examination end/or investigetion, in my opinion, death occurred et the time, date end placa, end due to tha cause(s) and manner stated.
29b. Signature and title of certifier
29c. License number: D 35164
29d. Data signed *(Month, Day, Year)*: July 29, 1999

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Andrew Zarick, Jr., M.D. 1080 West Patrick Street Frederick, MD 21703

State Registrar

31. Dete filed *(Month, Day, Year)*: JUL 29 1999
32. Registrar Signature: D. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified as soon.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25897

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Richard Carl THOMPSON Jr

2. Date of Death: Month July Day 31, Year 1999

3. Time of Death: 2:25 pm

4a. Facility Name (If not institution, give street and number): Frederick Health Care Center

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 215-26-7110

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 71 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug 15, 1927

9. Birthplace (State or Foreign Country): Washington DC

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Union Bridge

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 9001 Dolly Hyde Road

10f. Zip Code: 21791

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Farming

16b. Kind of Business/Industry: Agriculture

17. Father's Name (First, Middle, Last): Richard Carl THOMPSON Sr

18. Mother's Name (First, Middle, Maiden Surname): Mary Florentia SCHRANZ

19a. Informant's Name/Relationship (Type, Print): John Thompson/Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 509 East Mountain Rd, Knoxville, Maryland 21758

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt Olivet Cemetery Date: Aug 3, 1999

20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee: Keith Lynn Roberson M00706

22. Name and Address of Facility: Keeney & Basford P.A. Funeral Home 106 East Church St, Frederick, Maryland 21701

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Lymphoma — 2 mo.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Gene Ashe MD

29c. License number: D31058

29d. Date signed (Month, Day, Year): 8-2-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Gene F. Ashe, MD Woodsboro Medical Center, Woodsboro MD 21798

State Registrar

31. Date filed (Month, Day, Year): AUG 02 1999

32. Registrar's Signature: G. Spence

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25898

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William Garnett Thompson
2. Date of Death (Month, Day, Year): July 28, 1999
3. Time of Death: 10:15 pm
4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 219-14-8809
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 19, 1922
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 302 Maxwell Avenue
10f. Zip Code: 21701
10g. Citizen of What Country?: United States

11. Meritel Stetus: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Bleck, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 7 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Truck Driver
16b. Kind of Business/Industry: Farmers Co-operative

17. Father's Neme (First, Middle, Last): John Lynn Thompson
18. Mother's Name (First, Middle, Maiden Surname): Marcella Snowden

19a. Informent's Neme/Relationship (Type, Print): Erma E. Thompson/companion
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 302 Maxwell Ave., Frederick, Maryland 21701

20a. Method of Disposition: 1 [X] Buriel 2 [ ] Cremetion 3 [ ] Removel from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Piece of Disposition (Name of cemetery, crematory or other place): Ebenezer Cemetery
Dete: 8/2/99
20c. Location - City or Town, Stete: Ijamsville, Maryland

21. Signeture of Funerel Service Licensee: Jay Stauffer
22. Neme and Address of Feciility: Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702

Physician /Medical Examiner

23a. Part I. Enter the disesese, or complicetions that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

		Approximete Interval Between Onset and Deeth
Immediete Cause (Finel disease or condition resulting in deeth) a.	Chronic Obstructive Pulmonary Dis	> 10 YRS
Due to (or es a consequence of):		
Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in death) Lest b.		
Due to (or es a consequence of):		
c.		
Due to (or es a consequence of):		
d.		

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Pulmonary Emboli

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings aveilable prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Deeth (Check only one): Hospitel: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined
28a. Dete of Injury (Month, Dey Yeer):
28b. Time of Injury: M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred:
28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify):
28f. Location (Street and Number or Rural Route Number, City or Town, State):

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) end manner as stated. 2 [ ] Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and placa, end due to the cause(s) and menner steted.

29b. Signeture and title of certifier: Allen Gilson
29c. License number: D26516
29d. Date signed (Month, Day, Year): July 29 1999

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): Allen J. Gilson MD 1425 TANEY AVE FRED MD 21702

State Registrar

31. Dete filed (Month, Dey, Yeer): JUL 30 1999
32. Registrar's Signeture: Geneva G. Sparks

Baltimore, Maryland 21215-0020

permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriel-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25899

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Allene Godwin Taylor

2. Date of Death — Month: July; Day: 19; Year: 1999

3. Time of Death: 1630

4a. Facility Name *(If not institution, give street and number)*: PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 229-07-3094

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 79 Yrs.

If Under 1 Year — Months: ; Days: ; If Under 24 Hrs. — Hours: ; Min.:

8. Date of Birth *(Month, Day, Year)*: 4-24-20

9. Birthplace *(State or Foreign Country)*: VA

Usual Residence of Decedent

10a. State: VA

10b. County: (USA) Accomack Co.

10c. City, Town or Location: Mears

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 26273 Gladding Rd.

10f. Zip Code: 23409

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): Unkwn.; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Domestic

17. Father's Name *(First, Middle, Last)*: Thomas Godwin

18. Mother's Name *(First, Middle, Maiden Surname)*: Katherine Martin

19a. Informent's Name/Reletionship *(Type, Print)*: Granville Taylor, Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 26275 Gladding Rd., Mears, VA 23409

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Groton's Cemetery

Date: 7-21-99

20c. Location - City or Town, State: Hallwood, VA

21. Signature of Funeral Service Licensee: Melissa Kay Haney

22. Name and Address of Facility: BOUNDS FUNERAL HOME 705 E. MAIN ST. SALISBURY, MD

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. BRONCHOALVEOLAR CELL CARCINOMA — 16 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: R Chasse MD

29c. License number: D0046080

29d. Date signed *(Month, Day, Year)*: 7/20/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Robert Chasse, M.D. PRMC 100 E. Carroll St Salisbury, MD 21801

State Registrar

31. Date filed *(Month, Day, Year)*: JUL 27 1999

32. Registrar's Signature: Jeanne B Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

229-07-3094 Allene Taylor

6 copies

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25900

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HAROLD C. UPP, JR.

2. Date of Death: Month AUGUST Day 2 Year 1999

3. Time of Death: 0803

4e. Facility Name (If not institution, give street and number): SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 522-94-9406

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 28 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 19, 1970

9. Birthplace (State or Foreign Country): Maryland

Usual Residance of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Gaithersburg

10d. Insida City Limits: 1 [X] Yes 2 [ ] No

10e. Street end Number: 793 Quince Orchard Boulevard, #13

10f. Zip Code: 20878

10g. Citizan of What Country?: United States

11. Merital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorcad

12. Wes Decedent Ever in U,S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indien, Black, White, atc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elamentary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Volunteer

16b. Kind of Business/Industry: Library

17. Father's Nama (First, Middle, Last): Harold C. Upp, Sr.

18. Mother's Name (First, Middle, Meiden Surneme): Linda Pittman

19a. Informant's Name/Relationship (Type, Print): Harold C. Upp, Sr./Father

19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code): 793 Quince Orchard Blvd., #13, Gaithersburg, MD 20878

20a. Method of Disposition: 1 [X] Buriel 2 [ ] Cremation 3 [ ] Removel from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Woodside Cemetery Date: Aug. 6, 1999

20c. Location - City or Town, State: Brinklow, Maryland

21. Signature of Funeral Service Licensee: David E. Perry. M00803

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. CEREBRAL PALSY

Dua to (or as a consaquance of):

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest

b.

Due to (or as a consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: SEIZURE DISORDER

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Wara autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case refarrad to medical examiner? 1 [X] Yes 2 [ ] No

26. Piaca of Death (Check only one) Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Othar (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Panding investigation 6 [ ] Could not be detarmined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28a. Place of Injury - At home, ferm, street, factory, offica building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [ ] Certifying Phyaician: To the best of my knowledge, death occurred at tha time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On tha basis of examination and/or investigation, in my opinion, death occurred at tha tima, data and placa, and dua to the cause(s) and manner stated.

29b. Signature and title of certifier: M.D. (OME)

29c. License number: D15236

29d. Data signed (Month, Dey, Year): AUGUST 2, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CARL MARGOLIS, MD (OME) 11125 ROCKVILLE PIKE, ROCKVILLE MD 20852

State Registrar

31. Date filed (Month, Dey, Yaar): AUG 05 1999

32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(b)

6

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25901

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Henry Simon Ursic

2. Date of Death (Month, Day, Year): July 30, 1999

3. Time of Death: 1:30AM

4a Facility Name (If not institution, give street and number): 2359 Garrity Road

4b. City, Town, or Location of Death: St. Leonard

4c. County of Death: CALVERT

Funeral Director

5. Social Security Number: 193-16-0137

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 8, 1920

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County:

10c. City, Town or Location: St. Leonard

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10a. Street and Number: 2359 Garrity Rd.

10f. Zip Code: 20685

10g. Citizen of What Country?: U.S.A

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1942-1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4or 5+): 5

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): F.B.I Agent

16b. Kind of Business/Industry: U.S. Government

17. Father's Name (First, Middle, Last): John Ursic

18. Mother's Name (First, Middle, Maiden Surname): Elizabeth Kochne

19a. Informant's Name/Relationship (Type, Print): Patricia Ursic-Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2359 Garrity Rd., St. Leonard, MD 20685

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): National Crematory

Date: 8/5/99

20c. Location - City or Town, State: Falls Church, VA

21. Signature of Funeral Service Licensee: Thomas E. Hombaker

22. Name and Address of Facility: Joseph Gawler's Sons INC, 5130 Wisconsin Ave. NW, Washington, DC 20016

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Metastatic carcinoma to liver

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Bruce A. Silver, MD

29c. License number: D 21463

29d. Date signed (Month, Day, Year): July 30, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Bruce A. Silver, M. D. 110 Hospital Road #110 Prince Frederick, MD 20678

State Registrar

31. Date filed (Month, Day, Year): AUG 03 1999

32. Registrar's Signature: Jenna G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25902

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ERWIN FOSTER VANNOY
2. Date of Death: Month July Day 29 Year 1999
3. Time of Death: 0450
4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER
4b. City, Town, or Location of Death: SALISBURY
4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 111-03-7148
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 12, 1918
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Wicomico
10c. City, Town or Location: Delmar
10d. Inside City Limits: 1☒ Yes 2☐ No

10a. Street and Number: 300 S. Maryland AVe.
10f. Zip Code: 21875
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): -
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Quality Control
16b. Kind of Business/Industry: U.S. Government

17. Father's Name (First, Middle, Last): Foster Clinton VanNoy
18. Mother's Name (First, Middle, Maiden Surname): Margeurite Geer

19a. Informant's Name/Relationship (Type, Print): Margaret L. VanNoy/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 300 S. Maryland Ave., Delmar, MD 21875

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Salisbury Crematory
Date: 7/30/99
20c. Location - City or Town, State: Salisbury, MD

21. Signature of Funeral Service Licensee: M01051 David A. Thompson
22. Name and Address of Facility: Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): e. metastatic Bladder Cancer
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: David A. Thompson MD
29c. License number: D 20507
29d. Date signed (Month, Day, Year): 7/29/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): JOSEPH A. CRASSO 145 E CARROLL ST SALISBURY MD

State Registrar

31. Date filed (Month, Day, Year): JUL 30 1999
32. Registrar's Signature: Donna G Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

111-03-7148 Edwin F. VanNoy

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25903

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): VIRGINIA SEBASTIAN VAUGHN
2. Dete of Deeth: Month July Dey 31 Yeer 1999
3. Time of Death: 7:20 pm
4e. Feclity Neme (If not institution, give street and number): Wicomico Nursing Home
4b. City, Town, or Location of Death: Salisbury
4c. County of Deeth: Wicomico

Funeral Director

5. Sociel Security Number: 454-68-6249
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 93 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Yeer): OCT. 18, 1905
9. Birthplece (Stete or Foreign Country): MISSOURI

Usuel Residence of Decedent

10a. Stete: MARYLAND
10b. County: WICOMICO
10c. City, Town or Location: SALISBURY
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 900 BOOTH ST.
10f. Zip Code: 21801
10g. Citizen of Whet Country?: U.S.A.

11. Meritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.): 1☐ Yes 2☒ No Specify:
14. Reca - American Indien, Bleck, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12 College (1-4or 5+):
16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Fether's Neme (First, Middle, Last): CHARLES WESLEY SEBASTIAN
18. Mother's Name (First, Middle, Meiden Sumame): ELIZABETH ELKINS

19e. Informent's Name/Reletionship (Type, Print): J. DAVID VAUGHN
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code): 417 VIRGINIA AVE. SALISBURY, MD 21801

20a. Method of Disposition: 1☐ Buriel 2☒ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): CAMBRIDGE CREMATORY
Dete: 8/2/99
20c. Location - City or Town, Stete: CAMBRIDGE, MARYLAND

21. Signeture of Funerel Service Licensee: ▶ Robert W. Harris
22. Neme end Address of Feclity: BOUNDS FUNERAL HOME, INC. 705 E. MAIN ST SALISBURY, MD 21804

Physician /Medical Examiner

23a. Pert I. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Deeth

Immedlete Cause (Finel diseese or condition resulting in deelh): e. End Stage Alzheimer's Disease — 9 yrs

Due to (or es e consequence of):

Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Last:
b.
Due to (or es e consequence of):
c.
Due to (or es a consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Arteriosclerotic Cardiovascular Disease; Carcinoma, left axilla; Anemia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

28. Plece of Deeth (Check only one): Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred

28e. Plece of Injury - At home, ferm, street, factory, offica building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and menner es steted.
2☐ **Medical Examiner:** On the basis of exemination end/or investigetion, in my opinion, deeth occurred et the time, dete end plece, and due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: ▶ Gregorio M. Belloso M.D.
29c. License number: D 29505
29d. Date signed (Month, Dey, Yeer): 8-2-99

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Gregorio Belloso, M.D. 5302 Chinaberry Dr. Salisbury, MD 21801

State Registrar

31. Dete filed (Month, Dey, Yeer): AUG 03 1999
32. Registrar's Signeture: ▶ Pamela G Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Virginia Vaughn

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate hes been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25904

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Julia Ann Wassmann
2. Date of Death: Month July, Day 30, Year 1999
3. Time of Death: 1:27 AM
4a. Facility Name (If not institution, give street and number): 5809 SWARTHMORE DRIVE
4b. City, Town, or Location of Death: BERWYN HEIGHTS
4c. County of Death: PRINCE GEORGE'S

Funeral Director

5. Social Security Number: 215-17-3756
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 18 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): Nov.24,1980
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Berwyn Heights
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 5809 Swarthmore Drive
10f. Zip Code: 20740
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Student
16b. Kind of Business/Industry: Education

17. Father's Name (First, Middle, Last): Robert L. Wassmann
18. Mother's Name (First, Middle, Maiden Surname): Mary A. Fontaine

19a. Informant's Name/Relationship (Type, Print): Robert L. Wassmann (father)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5809 Swarthmore Drive Berwyn Heights, Maryland 20740

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. St. Mary's College Cemetery
Date: 8/2/99
20c. Location - City or Town, State: Emmitsburg,Maryland

21. Signature of Funeral Service Licensee: ▶ J. Kevin Stiles
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd.,W.,Silver Spring,MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death):
a. Cardiac Arrest
Due to (or as a consequence of):
b. Electrolyte Imbalance / dehydration — 1-2 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. feeding failure — 5 days
Due to (or as a consequence of):
d. Severe Neurologic disability Due to Prenatal Stroke at birth

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Severe developmental delay
Seizure disorder

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and Title of certifier: ▶ MD
29c. License number: D-17566
29d. Date signed (Month, Day, Year): 7/30/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Lawrence F Cohen MD 10313 Georgia Ave, Suite 303, Silver Spring, MD 20902

State Registrar

31. Date filed (Month, Day, Year): AUG 02 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25905

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Dorothy C. Windham
2. Date of Death: Month: August Day: 1 Year: 1999
3. Time of Death: 11:27 AM
4a. Facility Name (If not institution, give street and number): Suburban Hospital
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-20-4658
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 29, 1924
9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Chevy Chase
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 12 Hesketh Street
10f. Zip Code: 20815
10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1☐ Nevar Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yas 2☒ No If Yas, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Wilson Cecil
18. Mother's Name (First, Middle, Maiden Surname): Blanche Soper

19a. Informant's Name/Relationship (Type, Print): R. Craig Windham - Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10717 Kings Riding #201 Rockville, MD 20852

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): National Crematory
Date: 8/5/99
20c. Location - City or Town, State: Falls Church, VA

21. Signature of Funeral Service Licensee: Thomas E. Hannbaker
22. Name and Address of Facility: Joseph Gawler's Sons 5130 WI Ave. N.W. Washington, D. C. 20016

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Myocardial Infarction — 1 hr

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yas 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☐ Naturei 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Panding investigation 6☐ Could not be determined
28a. Data of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

29a. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Gary M. Rogers, MD
29c. License number: D04541
29d. Date signed (Month, Day, Year): 8/2/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GARY M ROGERS MD 10215 FERNWOOD RD #401 BETHESDA MD

State Registrar

31. Data filed (Month, Day, Year): AUG 05 1999
32. Registrar's Signature: Geneva G. Sparks

2697

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25906

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: LLOYD OWEN WENGER
2. Date of Death Month Day Year: AUGUST 5, 1999
3. Time of Death: 03:46
4a Facility Name *(If not institution, give street and number)*: Calvert Memorial Hospital
4b. City, Town, or Location of Death: Prince Frederick
4c. County of Death: Calvert

Funeral Director

5. Social Security Number: 578-03-5162
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: July 13, 1918
9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Calvert
10c. City, Town or Location: St. Leonard
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 7450 Sedwick Court
10f. Zip Code: 20685
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1944-45
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 | College (1-4or 5+):
16e. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Ordnance Supervisor
18b. Kind of Business/Industry: US Government

17. Father's Name *(First, Middle, Last)*: Edward L. Wenger
18. Mother's Name *(First, Middle, Maiden Surname)*: Emma W. Brightenbaugh

19a. Informent's Name/Reletionship *(Type, Print)*: Pauline C. Wenger-Wife
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 7450 Sedwick Court, St. Leonard, MD 20685

20e. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Trinity Memorial Gardens
Date: 8-7-99
20c. Location - City or Town, State: Waldorf, MD

21. Signature of Funeral Service Licensee: Mark G. Brohawn M00053
22. Name and Address of Facility: Huntt Funeral Home, Inc
P. O. Box 156, Waldorf, MD 20604-0156

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediete Ceuse (Finel disease or condition resulting in death)
a. SMALL CELL CARCINOMA OF LUNG — 6 MONTH
Due to (or as e consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditiona** contributing to death but not resulting in the underlying ceuse given in Part I.
ATRIAL FIBRILLATION
DIABETS

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings eveileble prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was cese referred to medicel examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Netural 2 [ ] Accident 3 [ ] Sulcide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred et the time, dete end place, and due to the cause(s) and menner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the ceuse(s) and manner stated.
29b. Signature and title of certifier: MD
29c. License number: D29657
29d. Date signed *(Month, Day, Year)*: 8/5/99

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): Dr. Charles Judge, M.D., Prince Frederick, Maryland 20678

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 06 1999
32. Registrar's Signature:

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

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To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25907

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Grace Kathryn Wilson

2. Date of Death (Month, Day, Year): July 27, 1999

3. Time of Death: 1:30 PM

4a. Facility Name (If not institution, give street and number): Homewood Retirement Center

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 213-09-8263

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 31, 1911

9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD.

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 238 N. Market St.

10f. Zip Code: 21701

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): seamstress

16b. Kind of Business/Industry: sewing co.

17. Father's Name (First, Middle, Last): John Cornelius Main

18. Mother's Name (First, Middle, Maiden Surname): Mollie Lucinda Routzahn

19a. Informant's Name/Relationship (Type, Print): Sue Scheffler (Niece)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7322 Coventry Dr., Middletown, MD. 21769

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Olivet Cemetery

Date: 8/2

20c. Location - City or Town, State: Frederick, MD.

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Donald B. Thompson Funeral Home, 31 E. Main St., Middletown, MD. 21769

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Chronic Obstructive Lung Disease — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Dementia Alzheimers Type

23b. **Did tobacco use contribute to the cause of death?** 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D 16428

29d. Date signed (Month, Day, Year): 8/2/99

30. Name and address of person who completed cause of death (Item 23a) (Type/Print): 300 W. 9th Street, Frederick, MD 21701

State Registrar

31. Date filed (Month, Day, Year): AUG 02 1999

32. Registrar's Signature: [signature] G. Sparks

Baltimore, Maryland 21215-0020

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DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25908

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOHN WILLIAMS JR.

2. Date of Death: Month AUGUST Day 3 Year 1999

3. Time of Death: 3:30PM

4a. Facility Name (If not institution, give street and number): 800 MOTTER AVE. APT. 712

4b. City, Town, or Location of Death: FREDERICK

4c. County of Death: FREDERICK

Funeral Director

5. Social Security Number: 216-14-6612

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 76 Yrs.

If Under 1 Year: Months ____ Days ____

If Under 24 Hrs.: Hours ____ Min. ____

8. Date of Birth (Month, Day, Year): NOV. 14, 1921

9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD.

10b. County: FREDERICK

10c. City, Town or Location: FREDERICK

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 800 MOTTER AVE. APT 712

10f. Zip Code: 21701

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [X] Yes 2 [ ] No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondary (0-12): 6 TH

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): IRON WORKER

16b. Kind of Business/Industry: IRON & STEEL

17. Father's Name (First, Middle, Last): JOHN WILLIAMS

18. Mother's Name (First, Middle, Maiden Surname): HATTIE CHASE

19a. Informent's Name/Relationship (Type, Print): SUNDAY FOSSETT

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 404 HEATHERIDGE DR. FREDERICK, MD. 21701

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): METRO CREMATORY

Date: AUG. 8, 1999

20c. Location - City or Town, State: BALT. MD.

21. Signature of Funeral Service Licensee: ▶ Gary L. Rollins

22. Name and Address of Facility: GARY L. ROLLINS FUNERAL HOME 110 WEST SOUTH ST FREDERICK MD 21701

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Arteriosclerotic Cardiovascular Disease — (10 years)

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Carcinoma of colon

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Austin Pearre, Jr.

29c. License number: D09689

29d. Date signed (Month, Day, Year): 8/6/99

30. Name and address of person who completed cause of death (Item 29a) (Type, Print): Dr. Austin Pearre, Jr. 300 W. 9th Street Frederick, Md 21701

State Registrar

31. Date filed (Month, Day, Year): AUG 06 1999

32. Registrar's Signature: ▶ B. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

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99 25909

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): WILBY H. WAGNER			2. DATE OF DEATH — MONTH: JULY DAY: 26 YEAR: 1999	3. TIME OF DEATH: 9:58 PM M
4. SOCIAL SECURITY NUMBER: 219-01-0883	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 77 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): JUNE 20, 1922	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): MANOKIN MANOR NURSING HOME		9b. CITY, TOWN OR LOCATION OF DEATH: PRINCESS ANNE		9c. COUNTY OF DEATH: SOMERSET

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: WICOMICO	10c. CITY, TOWN OR LOCATION: TYASKIN	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 4509 TYASKIN RD		10f. ZIP CODE: 21865	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: WWIII	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11 — College (1-4 or 5+): 3		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): MINISTER	16b. KIND OF BUSINESS/INDUSTRY: BAPTIST CHURCH
17. FATHER'S NAME (First, Middle, Last): JOHN C. WAGNER		18. MOTHER'S NAME (First, Middle, Maiden Surname): RHINEY RYAN	
19a. INFORMANT'S NAME (Type/Print): LINDA G. INSLEY		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4509 TYASKIN RD. TYASKIN, MD 21865	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): MARDELA MEMORIAL CEMETERY — DATE: 7/30/99	20c. LOCATION — City or Town, State: MARDELA, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ B. Keith Phippin CFSP		22. NAME AND ADDRESS OF FACILITY: BOUNDS FUNERAL HOME, INC. 705 E. MAIN ST. SALISBURY, MD 21804	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Arteriosclerotic Cardiovascular Disease	5 yrs
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Parkinson's Disease. CVA. Cerebro-vascular Disease. Ca of Prostate. Pneumonia

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [X] UNCERTAIN [ ]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] ND
28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Gregorio M. Belloso, M.D.	29c. LICENSE NUMBER: D29505	29d. DATE SIGNED (Month, Day, Year): ▶ 7-27-99

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
GREGORIO M. BELLOSO, M.D.; 5302 CHINABERRY DR., SALISBURY, MD 21801

31. DATE FILED (Month, Day, Year): JUL 30 1999	32. REGISTRAR'S SIGNATURE: Geneva G Sparks

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 26 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

CTB 958 pm 7/24/1999 Wilby Henry Wagner

27 VA

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25910

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HENRY CRAWFORD WILLIAMS
2. Date of Death Month: July Day: 25 Year: 1999
3. Time of Death: 2340
4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER
4b. City, Town, or Location of Death: SALISBURY
4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 215-26-4905
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 69 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JAN. 23, 1930
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: WICOMICO
10c. City, Town or Location: SALISBURY
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 609 E. LINCOLN AVE.
10f. Zip Code: 21804
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SUPERINTENDANT
16b. Kind of Business/Industry: CONSTRUCTION

17. Father's Name (First, Middle, Last): WILLIAM ERNEST WILLIAMS, SR.
18. Mother's Name (First, Middle, Maiden Surname): IVA MAE CAREY

19a. Informant's Name/Relationship (Type, Print): EDITH WILLIAMS- WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 609 E. LINCOLN AVE. SALISBURY, MD 21804

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): SHAD POINT CEMETERY
Date: 7/28/99
20c. Location - City or Town, State: SHAD POINT, MD

21. Signature of Funeral Service Licensee: Melissa Kay Henry
22. Name and Address of Facility: 705 E. MAIN ST. BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Respiratory Failure
Due to (or as a consequence of):
b. Pulmonary Embolus

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Adeno CA Stomach

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: H0054827
29d. Date signed (Month, Day, Year): 7/26/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MITCHELL GITTERMAN DO, 106 MAFORD ST SUITE 201 SALISBURY MD 21804

State Registrar

31. Date filed (Month, Day, Year): JUL 28 1999
32. Registrar's Signature: Donna G Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Henry Williams 215 26 4905

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25911

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Elvin Albert Zimmerman
2. Date of Death Month Day Year: July 31, 1999
3. Time of Death: 1:40 PM
4a. Facility Name *(If not institution, give street and number)*: 7905 Greentree Road
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-01-9641
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 91 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: October 2, 1907
9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Bethesda
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 7905 Greentree Road
10f. Zip Code: 20817
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Accountant
16b. Kind of Business/Industry: Pharmaceutical Company

17. Father's Name *(First, Middle, Last)*: David Edward Zimmerman
18. Mother's Name *(First, Middle, Maiden Surname)*: Lydia Ann Spangler

19a. Informent's Name/Relationship *(Type, Print)*: Edward M. Wusher/Executor
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 808 17th Street, N.W., Washington, D.C. 20006

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Rock Creek Cemetery — Date: August 7, 1999
20c. Location - City or Town, State: Washington, D.C.

21. Signature of Funeral Service Licensee: Michael F. Heggie — M00846
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Chronic Renal Failure	20 Years
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Hypertension	30 Years
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Peptic Ulcer Disease

Chronic Organic Brain Syndrome

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: D. V. Young, M.D.
29c. License number: DC8112
29d. Date signed *(Month, Day, Year)*: August 2, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David V. Young, M.D., 4530 Connecticut Avenue, N.W., Washington, D.C. 20008-4318

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 05 1999
32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25912

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BERTHA ZUSI AKA: BETTY ZUSI

2. Date of Death (Month, Day, Year): AUG. 2, 1999

3. Time of Death: 2:45 AM

4a. Facility Name (If not institution, give street and number): SUBURBAN HOSPITAL

4b. City, Town, or Location of Death: BETHESDA

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 025-36-5999

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 97 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JULY 18, 1902

9. Birthplace (State or Foreign Country): NEW JERSEY

Usual Residence of Decedent

10a. State: MD.

10b. County: MONTGOMERY

10c. City, Town or Location: BETHESDA

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 4700 EDGEFIELD RD.

10f. Zip Code: 20814

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER

16b. Kind of Business/Industry: HOME

17. Father's Name (First, Middle, Last): JACOB LEONZ

18. Mother's Name (First, Middle, Maiden Surname): BERTHA BERTSCHI

19a. Informant's Name/Relationship (Type, Print): RICHARD L. ZUSI/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): SAME AS ITEM #10

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): CHAMBERS CREMATORY | Date: 8/3/99

20c. Location - City or Town, State: RIVERDALE, MD.

21. Signature of Funeral Service Licensee: W.W. Chambers MO0091

22. Name and Address of Facility: CHAMBERS FUNERAL HOMES, P.A., SILVER SPRING, MD. 20906

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. PULMONARY EDEMA — HOURS

Due to (or as a consequence of):
b. CONGESTIVE HEART FAILURE — DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. ACUTE RENAL FAILURE — HOURS

Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ATRIAL FIBRILLATION

HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Yuri A. Deychak

29c. License number: 041311

29d. Date signed (Month, Day, Year): AUG. 2, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): YURI DEYCHAK, M.D. 6410 ROCKLEDGE DR., BETHESDA, MD.

State Registrar

31. Date filed (Month, Day, Year): AUG 03 1999

32. Registrar's Signature: Laura G. Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Zusi, Bertha 8/2/99 2:45AM

5

DHMH 16 Rev 6/95

ORIGINAL

99-4489-013
CJ
Kristin Diane
Zorn

Amended #5 Per F.D., 8/9/99, Carroll County, wjl

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25913

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Kristin Diane Zorn
2. Date of Death: Month July, Day 30, Year 1999
3. Time of Death: 09:01 PM.
4a. Facility Name (If not institution, give street and number): Route 26 east of Route 32
4b. City, Town, or Location of Death: Eldersburg
4c. County of Death: Carroll

Funeral Director

5. Social Security Number: ~~217-13-4853~~ 217-13-4856
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 16 Yrs. — If Under 1 Year: Months, Days; If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): March6,1983
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.
10b. County: Carroll
10c. City, Town or Location: Eldersburg
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1812 Liberty Road
10f. Zip Code: 21784
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Student
16b. Kind of Business/Industry: Liberty High School

17. Father's Name (First, Middle, Last): David Zorn
18. Mother's Name (First, Middle, Maiden Surname): Kathleen Allen

19a. Informant's Name/Relationship (Type, Print): Kathleen Inskeep/Mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1812 Liberty Road Eldersburg, Maryland 21784

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Carroll Cremation, Inc.
Date: 8/2/1999
20c. Location - City or Town, State: Hampstead, Maryland

21. Signature of Funeral Service Licensee: ▶ Jeffrey N. Zumbrun
22. Name and Address of Facility: Jeffrey N. Zumbrun Funeral Home, 6028 Sykesville Road Eldersburg, Maryland 21784

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Multiple Injuries

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Scene

27. Manner of Death: 1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year): 7/30/99
28b. Time of Injury: 2048 M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: Pedestrian struck by vehicle
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): STREET
28f. Location (Street and Number or Rural Route Number, City or Town, State): RTE. 26 W/of Georgetown Blvd.

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ J. Aaron Locke MD
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): July 31, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. AARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): AUG 0 2 1999
32. Registrar's Signature: ▶ Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25914

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Baby Boy Zerne, JACOB
2. Date of Death: Month July, Day 29, Year 1999
3. Time of Death: 2004
4a. Facility Name (If not institution, give street and number): University of Maryland
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: N/A
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 0 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min. 45
8. Date of Birth (Month, Day, Year): JULY 29, 1999
9. Birthplace (State or Foreign Country): MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD.
10b. County: FREDERICK
10c. City, Town or Location: FREDERICK
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1453 MOBLEY COURT
10f. Zip Code: 21701
10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): N/A; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): N/A
16b. Kind of Business/Industry: N/A

17. Father's Name (First, Middle, Last): ROGER ANDERS ZERNE
18. Mother's Name (First, Middle, Maiden Surname): LOLA ELIZABETH SANTOS

19a. Informant's Name/Relationship (Type, Print): ROGER A. ZERNE (FATHER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1453 MOBLEY COURT FREDERICK MD. 21701

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): METRO CREMATORT
Date: AUG. 2, 1999
20c. Location - City or Town, State: BALTIMORE MD.

21. Signature of Funeral Service Licensee: ▶ Gary L. Rollins
22. Name and Address of Facility: GARY L. ROLLINS FUNERAL HOME 110 WEST SOUTH ST. FREDERICK, MD 21701

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Severe Anomaly [Anencephaly]

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Sulcide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ C Greenberg MD
29c. License number: P10338
29d. Date signed (Month, Day, Year): 7/29/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Carol S. Gaundry University Hospital Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year): AUG 06 1999
32. Registrar's Signature: ▶ Lenora B. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25915

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Arthur ZELL
2. Date of Death (Month, Day, Year): August 4, 1999
3. Time of Death: 5:00 AM
4a. Facility Name (If not institution, give street and number): Northampton Manor Nursing Home
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 223-09-6889
6. Sex: XX 1 M 2 F
7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 17, 1913
9. Birthplace (State or Foreign Country): Wash., D.C.

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1 X Yes 2 ☐ No
10e. Street and Number: 450 West South Street
10f. Zip Code: 21701
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married XX Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 XX No Specify:
14. Race - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Oil BurnerMechanic/ Electrician
16b. Kind of Business/Industry: Fuel Oil Company

17. Father's Name (First, Middle, Last): Martin ZELL
18. Mother's Name (First, Middle, Maiden Surname): Grace MANION

19a. Informant's Name/Relationship (Type, Print): Mrs. Carol Litton, Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 450 West South St., Frederick, Md. 21701

20a. Method of Disposition: X 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mount Olivet Cemetery, Date: Aug. 6, 1999
20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee: ▶ Richard E. Fry M00255
22. Name and Address of Facility: Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick, Md. 21701

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Metastatic Colon Cancer — Months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 X Neturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of Certifier: ▶
29c. License number: D43091
29d. Date signed (Month, Day, Year): August 4, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SAEED ZAIDI 801 TOLL HOUSE AVE, Frederick, MD

State Registrar

31. Date filed (Month, Day, Year): AUG 05 1999
32. Registrar's Signature: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 25916

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARY PEARL ADAMS

2. Date of Death — Month: August; Day: 16; Year: 1999

3. Time of Death: 250 AM

4a. Facility Name *(If not institution, give street and number)*: Maryland General Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-32-2806

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 63 Yrs.

If Under 1 Yaar — Months: ; Days:

If Under 24 Hrs. — Hours: ; Min.:

8. Date of Birth *(Month, Dey, Year)*: APR. 11, 1936

9. Birthplece *(Stete or Foraign Country)*: MD.

To Be Completed by Funeral Director

Usuel Residence of Decedent

10a. Steta: MD.

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 307 S. LEHIGH ST.

10f. Zip Code: 21224

10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐ Never Merried 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forcas? 1☐ Yes 2☒ No — If Yes, Give Year or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Bleck, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondery (0-12): 9TH; College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: DOMESTIC

16b. Kind ot Business/Industry: CLEANINGSERVICE

17. Fether's Neme *(First, Middle, Last)*: ELMER ROBINSON

18. Mother's Name *(First, Middle, Meiden Surneme)*: MARY LORETTA MASON

19a. Intorment's Name/Reletionship *(Type, Print)*: PAT SENTZ/DAUGHTER

19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 6532 RIVERVIEW AVE., BALTIMORE, MD. 21222

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from Stete 4☐ Donation 5☐ Other *(Specify)*

20b. Piece ot Disposition *(Neme of cemetery, cremetory or other piece)*: OAK LAWN CEMETERY

Dete: 8/19/99

20c. Location - City or Town, State: BALTIMORE, MD.

21. Signeture of Funeral Service Licensee: Elizabeth Schnabe

22. Nama and Addrass of Facility: CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVE., BALTIMORE, MD. 21224

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Pert I. Enter tha disease, or complicetions thet caused tha death. Do not anter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximata tnterval Between Onset and Deth

tmmediete Ceuse (Finel diseese or condition resulting in deth): a. Cerebral Hypoxia

Due to (or es e consequence ot):

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury thet initieted events rasulting in death) Last

b.

Due to (or es e consequence of):

c.

Dua to (or es e consequence ot):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: History of Bladder Cancer

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Wes an eutopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy tindings aveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case reterred to medical examiner? 1☐ Yes 2☑ No

26. Piece ot Deeth *(Check only one)*: Hospitel: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner ot Deeth: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date ot Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, term, street, tactory, office building, etc. *(Specify)*

28t. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best ot my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examtner:** On the basis ot exeminetion end/or investigetion, in my opinion, deeth occurred et the time, dete end piece, and due to the ceuse(s) end manner steted.

29b. Signetura and title of certifier: Jodeep Mencherry, M.D.

29c. Licanse number: 89351

29d. Data signed *(Month, Dey, Year)*: 8/16/99

30. Name end eddress ot person who completed cause of deeth (Item 23e) (Type, Print): Jodeep Mencherry, M.D. 40 Maryland General Hospital

State Registrar

31. Dete tiled *(Month, Dey, Year)*: AUG 18 1999

32. Registrer's Signeture: L. Sparks

DHMH 16 Rev 6/95

To the Hospital or Attending Physician: Tha law requiras thet the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Mary Adams

A25

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25917

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARIAN R. ALBERT
2. Date of Death (Month, Day, Year): AUGUST 16, 1999
3. Time of Death: 8:00 P.M.
4a. Facility Name *(If not institution, give street and number)*: 601 KUETHE RD.
4b. City, Town, or Location of Death: GLEN BURNIE
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 217-24-4057
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 72 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: MARCH 10, 1927
9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: GLEN BURNIE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 601 KUETHE RD.
10f. Zip Code: 21060
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yas 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highast grada complated)*: Elementery/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usuel Occupation *(Give kind of work dona during most of working life. DO NOT use retired)*: HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name *(First, Middle, Last)*: GEORGE MEISENHOLDER
18. Mother's Neme *(First, Middle, Maiden Surname)*: MARIE FLYNN

19e. Informant's Neme/Relationship *(Type, Print)*: JAMES G. ALBERT / SON
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 601 KUETHE RD., GLEN BURNIE, MARYLAND 21060

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from Stata 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: OUR LADY OF THE FIELDS CEM. — Date: 8/19/99
20c. Location - City or Town, Stata: MILLERSVILLE, MARYLAND

21. Signeture of Funeral Service Licensee: [signature]
22. Name end Address of Facility: KIRKLEY-RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061

Physician /Medical Examiner

23a. Part1. Enter tha disease, or complications that causad tha death. Do not enter tha moda of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Renal Cell Carcinoma — 6 Months
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Dua to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accidant 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) end menner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and piece, and due to the ceuse(s) and manner stated.

29b. Signatura and title of certifier: [signature] M.D.
29c. License number: D39505
29d. Date signed *(Month, Day, Year)*: AUGUST 17, 1999

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Yudhish Markan 1600 Crain Hwy, Glen Burnie, MD. 21061

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 18 1999
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25918

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Emma Josephine Anzer
2. Date of Death (Month, Day, Year): August 14, 1999
3. Time of Death: 1:50 P.M.
4a. Facility Name (If not institution, give street and number): Fallston General Hospital
4b. City, Town, or Location of Death: Fallston
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 214-18-7790
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): October 18, 1919
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 5919 Plumer Avenue
10f. Zip Code: 21206
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11th. Grade; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Frederick Wenker
18. Mother's Name (First, Middle, Maiden Surname): Anna Draeger

19a. Informant's Name/Relationship (Type, Print): Lawrence G. Anzer / Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5919 Plumer Avenue Baltimore MD 21206

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Balto./Wash. Crematory | Date: 08/16/99
20c. Location - City or Town, State: Laurel MD

21. Signature of Funeral Service Licensee: Billy M. Blake
22. Name and Address of Facility: John C. Miller, Inc. 6415 Belair Road Baltimore MD 21206

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. SMALL BOWEL OBSTRUCTION — 5 DAYS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
ESOPHAGEAL CARCINOMA
SMALL CELL UNDIFFERENTIATED CANCER

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: John P. Edwards MD
29c. License number: D31775
29d. Date signed (Month, Day, Year): AUGUST 14, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOHN P. EDWARDS, M.D. 2112 BELAIR ROAD FALLSTON, MARYLAND 21047

State Registrar

31. Date filed (Month, Day, Year): AUG 18 1999
32. Registrar's Signature: L. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

AH6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25919

AMEND ITEM: #23 PART I, 29C PER MEO G775 9-2-99 WR.

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jessie Burns
2. Date of Death: Month AUG Day 15 Year 99
3. Time of Death: 12:50 PM
4a. Facility Name (If not institution, give street and number): ST AGNES HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 239-07-2436
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): 03 30 10
9. Birthplace (State or Foreign Country): G.A.

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 2473 Druid Hill Ave
10f. Zip Code: 21217
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): NA; College (1-4or 5+): NA
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Unknown
16b. Kind of Business/Industry: Unknown

17. Father's Name (First, Middle, Last): Unknown
18. Mother's Name (First, Middle, Maiden Surname): Unknown

19a. Informant's Neme/Reletionship (Type, Print): Asalee Williams-Friend
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3902 Woodridge Road, Baltimore Md 21229

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt Zion Cemetery
Date: 8/17/99
20c. Location - City or Town, Stete: Baltimore, Md

21. Signature of Funeral Service Licensee: Sharon S. Rice
22. Name and Address of Facility: March F/H West 4300 Wabash Ave, Baltimore Md 21215

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. CARDIAC ARREST	70 MIN
	Due to (or as a consequence of): CHF, ATRIAL FIBRILLATION	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

~~CHF, ATRIAL FIBRILLATION~~

MENTAL STATUS CHANGE

DEMENTIA, DEPRESSION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the tima, date and place, and due to the cause(s) and menner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner steted.

29b. Signeture and title of certifier: Ane Konan, MD
29c. License number: P-12704
29d. Date signed (Month, Day, Year): SEPTEMBER 2, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ~~ANNA~~ KORNAN 900 CATON AVE BALTIMORE, MARYLAND 21229

State Registrar

31. Date filed (Month, Day, Year): AUG 31 1999
32. Registrar's Signature: Lenora G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

NAME BURNS, JESSIE

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25920

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Reginald Bennett
2. Date of Death (Month, Day, Year): August 10, 1999
3. Time of Death: 2:50 AM
4a. Facility Name (If not institution, give street and number): Good Samaritan Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 214-50-4569
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 50 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): Oct. 9, 1948
9. Birthplace (State or Foreign Country): Maryland

Usual Residance of Decedant

10a. Steta: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yas 2 [ ] No
10e. Street and Number: 2014 Ruxton Ave.
10f. Zip Code: 21216
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Evar in U.S. Armed Forcas? 1 [X] Yas 2 [ ] No If Yas, Giva Yaar or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puerto Rican, atc.): 1 [ ] Yas 2 [X] No Specify:
14. Race - American Indien, Bleck, White, atc. Specify: Black

15. Decedant's Education (Specify only highest grada complatad): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 2
16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use ratired): Clerk
16b. Kind of Businass/Industry: Social Security Adm.

17. Father's Name (First, Middle, Last): Leroy Bennett
18. Mother's Neme (First, Middle, Meiden Surneme): Delma Randall

19a. Informant's Name/Ralationship (Type, Print): Ms. Alicia Bennett (daughter)
19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Coda): 6025 Barstow Rd. Balto. Md. 21206

20a. Mathod of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Othar (Specify)
20b. Piece of Disposition (Nama of cematary, cramatory or othar placa): Garrison Forest
Date: 8/16/99
20c. Location - City or Town, Stata: Owings Mills, Md.

21. Signature of Funarel Service Licensee: Joseph L. Russ
22. Nama and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

Physician /Medical Examiner

23a. Part I. Enter the disaasa, or complications that caused the daath. Do not anter tha moda of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only ona cause on aach lina.

Approximate Interval Batween Onsat and Death

Immediata Causa (Finel disaasa or condition rasulting in death):
a. Massive Bleeding — 12 hrs.
Due to (or as a consequanca of):
b. Coagulopathy
Due to (or as a consequence of):
c. Liver Cirrhosis
Due to (or as a consaquance of):
d. Alcohol, Hepatitis B & C

Sequentially list conditions, if any, leading to immadiata cause. Entar Underlying Cause (Disease or injury that initiated events rasulting in death) Last

Part II. Other significant conditions contributing to death but not rasulting in the underlying causa given in Part I.
Dehydration
HIV

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yas 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Wara autopsy findings available prior to compiation of cause of death? 1 [ ] Yes 2 [X] No

25. Was case rafarred to medical examiner? 1 [ ] Yas 2 [X] No

26. Place of Deeth (Chack only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Homa 5 [ ] Rasidanca 6 [ ] Othar (Specify)

27. Mennar of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Data of Injury (Month, Dey Year)
28b. Tima of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28a. Place of Injury - At homa, farm, streat, factory, offica building, etc. (Specify)
28f. Location (Street and Number or Rural Routa Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To tha best of my knowledge, deeth occurred at the time, data end piace, and due to the cause(s) and menner es stated. 2 [ ] Medical Examiner: On tha basis of axaminatlon and/or Invastigation, in my opinion, death occurred at the time, deta and placa, and due to the ceuse(s) end mennar statad.

29b. Signeture end title of certifier: Michel Skaf, MD
29c. Licensa number: P11391
29d. Date signed (Month, Day, Year): August 18, 1999

30. Nema and address of person who complated causa of death (Item 23a) (Type, Print): Michel Skaf 5601 Loch Raven Blvd Baltimore MD 21239.

State Registrar

31. Data filed (Month, Day, Year): AUG 18 1999
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

, MD 21215

A14641

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25921

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RORY DEAN BECK
2. Date of Death (Month, Day, Year): AUGUST 16, 1999
3. Time of Death: 7:35 AM
4a. Facility Name (If not institution, give street and number): 6811 PIMLICO DRIVE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 215-50-5361
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 48 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JAN. 10, 1951
9. Birthplace (State or Foreign Country): OH

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 6811 PIMLICO DRIVE
10f. Zip Code: 21209
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 4 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LOAN OFFICER
16b. Kind of Business/Industry: MORTGAGE

17. Father's Name (First, Middle, Last): ROBERT G. BECK
18. Mother's Name (First, Middle, Meiden Surname): DELORES DEMKO

19a. Informant's Name/Relationship (Type, Print): LINDA BECK / WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6811 PIMLICO DRIVE - BALTIMORE, MD 21209

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): BETH EL MEMORIAL PARK
Date: 8/17/99
20c. Location - City or Town, State: RANDALLSTOWN, MD

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finat disease or condition resulting in death)
a. Metastatic Renal Carcinoma — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or es a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residenca 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated.

29b. Signature and title of cartifier: ▶ [signature] M.D.O.
29c. License number: H47494
29d. Date signed (Month, Dey, Year): 8/16/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): [signature] M.D. O. 21 Cross Roads, Suite 250, Baltimore, MD 21208

State Registrar

31. Date filed (Month, Dey, Year): AUG 18 1999
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Rory Beck

414 10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25922

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LOUIS BRODNICK
2. Date of Death (Month, Day, Year): AUGUST 13, 1999
3. Time of Death: 7:11 AM
4a. Facility Name (If not institution, give street and number): 3921 BANCROFT ROAD
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-05-6786
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 80 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JAN. 3,1919
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: XX Yes 2 [ ] No
10a. Street and Number: 3921 BANCROFT ROAD
10f. Zip Code: 21215
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SALES
16b. Kind of Business/Industry: WARNER-LAMBERT CO.

17. Father's Name (First, Middle, Last): BENJAMIN BRODNICK
18. Mother's Name (First, Middle, Maiden Surname): ELIZABETH FISHER

19a. Informant's Name/Relationship (Type, Print): FLORENCE BRODNICK / WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3921 BANCROFT ROAD - BALTIMORE, MD 21215

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ARLINGTON CHIZUK AMUNO
Date: 8/15/99
20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee: Robert Levinson
22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Lymphoma
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: M Passer M.D.
29c. License number: D42561
29d. Date signed (Month, Day, Year): 8/13/99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Martin Passer, M.D. 21 Crossroads Dr. #400 Owings Mills, MD 21117

State Registrar

31. Date filed (Month, Day, Year): AUG 18 1999
32. Registrar's Signature: Penny D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

14415

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25923

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOAN ELIZABETH BETLEY
2. Date of Death Month Day Year: AUGUST 11, 1999
3. Time of Death: 6:15P.M.

4a. Facility Name (If not institution, give street and number): CANTON HARBOR FUTURE CARE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-20-4599
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JUNE 28, 1925
9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD.
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 17 S. ROBINSON ST.
10f. Zip Code: 21224
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8TH | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): THOMAS GRAY
18. Mother's Name (First, Middle, Maiden Surname): CARRY SCHECK

19a. Informant's Name/Relationship (Type, Print): MICHAEL G. BETLEY, SR./HUSBAND
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 17 S. ROBINSON ST. BALTIMORE, MD. 21224

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): SACRED HEART OF JESUS
Date: 8/14/99
20c. Location - City or Town, State: BALTIMORE, MD.

21. Signature of Funeral Service Licensee: Richard T. Stewart III 8/13/99
22. Name and Address of Facility: CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVE. BALTIMORE, MD. 21224

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Arteriosclerotic Heart Disease	7 yrs
Due to (or as a consequence of): b.	Arteriosclerosis	7 yrs
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last: Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Cerebrovascular accident
Diabetes mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Melito M. Torres
29c. License number: D11150
29d. Date signed (Month, Day, Year): 8/13/1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MELITO M. TORRES, MD 4415 ELLWOOD AVE, BALTO MD 21224

State Registrar

31. Date filed (Month, Day, Year): AUG 18 1999
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25924

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EVELYN MAY BUSCH
2. Date of Death: Month AUGUST Day 16 Year 1999
3. Time of Death: 06 35
4a. Facility Name (If not institution, give street and number): ST AGNES HEALTHCARE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death:

Funeral Director

5. Social Security Number: 216.20.7287
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 71 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 4, 1928
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Pasadena
10d. Inside City Limits: 1☐ Yes 2☐ No
10e. Street and Number: 8105 Dewberry Circle Apt. 1705
10f. Zip Code: 21122-7141
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cashier
16b. Kind of Business/Industry: Parmacy

17. Father's Name (First, Middle, Last): William Strunkle
18. Mother's Name (First, Middle, Maiden Surname): Minnie Shoemaker

19a. Informant's Name/Relationship (Type, Print): Janet L. Feldman
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 548 Parksley Ave. Baltimore, Maryland 21223-2728

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Glen Haven Memorial Park
Date: 8-19-99
20c. Location - City or Town, State: Glen Burnie, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Singleton Funeral Home, PA
1 Second Ave. S.W. Glen Burnie, Maryland 21061

Physician /Medical Examiner

23a. Part I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	OVERWHELMING SEPSIS	few days
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.	BACTERIAL ENDOCARDITIS	Month
Due to (or as a consequence of):		
c.	DEMENTIA	Years
Due to (or as a consequence of):		
d.		

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] MEDICAL DOCTOR
29c. License number: P12597
29d. Date signed (Month, Day, Year): AUGUST 16, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): WORLALI NUTAKOR, ST. AGNES HOSPITAL, 900 CATON AVE - BALTIMORE, MD 21229

State Registrar

31. Date filed (Month, Day, Year): AUG 18 1999
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

NAME BUSCH, EVELYN M.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25925

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
VANCE	EDGAR	BARLOW	AUGUST	17,	1999	8:00 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
MARINER HEALTH OF NORTH ARUNDEL	GLEN BURNIE	ANNE ARUNDEL

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Yaar: Months	Days	If Undar 24 Hrs.: Hours	Min.	8. Data of Birth (Month, Day, Yaar)	9. Birthplace (State or Foreign Country)
234-22-0863	XX 1 M 2 F	76 Yrs.					OCT. 21, 1922	WEST VIRGINIA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	ANNE ARUNDEL	GLEN BURNIE	1 ☐ Yas 2 ☒ No

10e. Street and Number	10f. Zip Coda	10g. Citizan of What Country?
104 GLENDALE AVENUE	21061	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forcas?	13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.)	14. Race - American Indian, Black, Whita, atc.
1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☒ Yas 2 ☐ No If Yas, Give Yaar or Datas: 1943-1946	1 ☐ Yas 2 ☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highast grada completed)		16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired)	16b. Kind of Businass/Industry
Elamantary/Sacondary (0-12)	Collaga (1-4or 5+)		
10		ELECTRICIAN	TIEDER ELECTRIC CO.

17. Father's Name (First, Middle, Last)	18. Mothar's Nama (First, Middla, Maidan Sumame)
WILLIAM E. BARLOW	EMILY H. BOOTHE

19a. Informant's Name/Ralationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)
LORA J. BARLOW (WIFE)	104 GLENDALE AVENUE, GLEN BURNIE, MD. 21061

20a. Mathod of Disposition	20b. Piaca of Disposition (Nama of cematary, crematory or other piaca)	Data	20c. Location - City or Town, Stata
1 ☒ Burial 2 ☐ Cramation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Othar (Specify)	GLEN HAVEN MEMORIAL PARK	8/19/99	GLEN BURNIE, MD.

21. Signatura of Funaral Service Licensaa	22. Name and Address of Facility
▶	SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

Physician /Medical Examiner

23a. Part I. Entar the disaasa, or complications that caused the daath. Do not antar the moda of dying, such as cardiac or raspiratory errest, shock, or hiddan failura. List only ona causa on aach lina.

		Approximate Interval Batween Onset and Death
Immadiata Causa (Final disaasa or condition rasulting in daath)	a. ASPIRATION PNEUMONIA	1 DAY
Dua to (or as a consaquanca of):	b. PARKINSON DISEASE	5 YEARS
Saquantially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disaasa or injury that initiatad avants rasulting in daath) Last	Dua to (or as a consaquanca of): c.	
	Dua to (or as a consaquanca of): d.	

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying cause given in Part I.

DEMENTIA

CEREBROVASCULAR DISEASE

23b. Did tobacco use contributa to the causa of death?	24a. Was an autopsy performed?	24b. Wara autopsy findings available prior to completion of causa of death?
1 ☐ Yaa 2 ☐ No 3 ☐ Probably 4 ☒ Unknown	1 ☐ Yas 2 ☒ No	1 ☐ Yas 2 ☐ No

25. Was casa referred to medical examinar?	26. Placa of Death (Check only ona)	
1 ☐ Yas 2 ☒ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Othar: 4 ☒ Nursing Home 5 ☐ Rasidanca 6 ☐ Othar (Specify)

27. Mannar of Death	28a. Data of Injury (Month, Day Yaar)	28b. Tima of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 ☒ Natural 2 ☐ Accidant 3 ☐ Suicida 4 ☐ Homicida 5 ☐ Panding investigation 6 ☐ Could not ba determinad		M	1 ☐ Yas 2 ☐ No	
	28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify)			28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one)

1 ☐ **Certifying Physician:** To the best of my knowledga, daath occurrad at the tima, data and placa, and dua to tha causa(s) and manner as stated.

2 ☒ **Madical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signatura and title of certifier	29c. Licansa number	29d. Data signed (Month, Day, Yaar)
▶ M.D.	D-22609	AUGUST 17, 1999

30. Nama and addrass of parson who completed cause of daath (Item 23a) (Type, Print)

RUBEN REIDER M.D. 7445 FURNACE BRANCH RD Glen Burnie MD 21060

State Registrar

31. Data filed (Month, Day, Yaar)	32. Registrar's Signatura
AUG 18 1999	Jeanne B. Spahr

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

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Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25926

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DANIEL W. BEAZLEY
2. Date of Death (Month, Day, Year): AUGUST 16, 1999
3. Time of Death: 9:00 P.M.
4a. Facility Name (If not institution, give street and number): 1306 WILLIAMS STREET
4b. City, Town, or Location of Death: GLEN BURNIE
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 224-38-1045
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 67 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MAY 25, 1932
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: GLEN BURNIE
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1306 WILLIAMS STREET
10f. Zip Code: 21061
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 2 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SHEET METAL WORKER
16b. Kind of Business/Industry: METAL FABRICATION

17. Father's Name (First, Middle, Last): JAMES WILLARD BEAZLEY
18. Mother's Name (First, Middle, Maiden Surname): MABEL R. ARNOLD

19a. Informant's Name/Relationship (Type, Print): FRANCES T. BEAZLEY /WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1306 WILLIAMS ST., GLEN BURNIE, MD 21061

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): GLEN HAVEN MEM. PK.
Date: AUG. 20 1999
20c. Location - City or Town, State: GLEN BURNIE, MARYLAND

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: KIRKLEY-RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Aspiration Pneumonia	7/24/99
Due to (or as a consequence of): b.	Temporal Astrocytoma	4/98
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D31944
29d. Date signed (Month, Day, Year): AUGUST 17, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): H. GEORGE HEBARD, 1600 CRAIN HIGHWAY, SUITE 208, GLEN BURNIE, MD 21061

State Registrar

31. Date filed (Month, Day, Year): AUG 18 1999
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25927

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Herbert W. Browning
2. Date of Death (Month, Day, Year): August 15, 1999
3. Time of Death: 12:30 PM
4a. Facility Name *(If not institution, give street and number)*: 2811 E. Joppa Road
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-03-5727
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 85 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 12/15/1913
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 2811 E. Joppa Road
10f. Zip Code: 21234
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Machinist
16b. Kind of Business/Industry: Western Electric

17. Father's Name *(First, Middle, Last)*: William Browning
18. Mother's Name *(First, Middle, Maiden Surname)*: Bessie (Unknown)

19a. Informant's Name/Relationship *(Type, Print)*: Eleanor Browning/Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2811 E. Joppa Road Baltimore, Maryland 21234

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Parkwood Cemetery — Date: 8/18/99
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ARTERIOSCLEROTIC CARDIOVASCULAR DIS.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: SQUAMOUS CELL CARCINOMA

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D26677
29d. Date signed *(Month, Day, Year)*: 8/16/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 18 1999
32. Registrar's Signature: [signature] G. Sparks

AHC

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

ADH
GARY L. BROHAWN, JR.
99-4678-005

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25928

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Gary L. Brohawn, Jr.
2. Date of Death: Month AUGUST Day 12 Year 1999
3. Time of Death: 1820 PM
4a. Facility Name (If not institution, give street and number): 10820 BEAVER DAM ROAD
4b. City, Town, or Location of Death: COCKEYSVILLE
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 212-74-0517
6. Sex: 1 ☐ M 2 ☐ F — X
7. Age (In yrs. last birthday): 42 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 10, 1957
9. Birthplace (State or Foreign Country): Baltimore, MD.

Usual Residence of Decedent

10a. State: Florida
10b. County: Pasco
10c. City, Town or Location: Port Ritchie
10d. Inside City Limits: 1 ☐ Yes 2 ☐ No — X
10e. Street and Number: 8921 Lido lane
10f. Zip Code: 34668
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No — If Yes, Give Year or Dates: X
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No — Specify:
14. Race - American Indian, Black, White, etc. — Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerk
16b. Kind of Business/Industry: Food Service

17. Father's Name (First, Middle, Last): Gary L. Brohawn, Sr
18. Mother's Name (First, Middle, Maiden Surname): Yvonne Beckett

19a. Informant's Name/Relationship (Type, Print): Jerri H. Hercheck (Sister)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 927 Jackson Blvd. Bel Air, Md. 21014

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Piece of Disposition (Name of cemetery, crematory or other place): Metro Crematory, Inc.
Date: August 14, 1999
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Heather Lassahn Chojnacki
22. Name and Address of Facility: Lassahn Funeral Home, Inc. 7401 Belair Road Baltimore, Maryland 21236-4625

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Drowning complicating
~~Due to (or as a consequence of):~~
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Atherosclerotic Cardiovascular
~~Due to (or as a consequence of):~~
c. Disease
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☒ Yes 2 ☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) AT SCENE

27. Manner of Death: 1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year): 08.12.99
28b. Time of Injury: 1500 M
28c. Injury at Work? 1 ☐ Yes 2 ☒ No
28d. Describe how injury occurred: Subject Drowned
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Quarry; Beaver Dam Swim Club
28f. Location (Street and Number or Rural Route Number, City or Town, State): 10820 Beaver Dam Road Cockeysville MD

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J Pattaman M.D.
29c. License number: OCME
29d. Date signed (Month, Day, Year): AUGUST 13, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): AUG 18 1999
32. Registrar's Signature: Jeanne G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

945

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25929

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BERNARD D. CARMEL
2. Date of Death: Month AUGUST Day 14 Year 1999
3. Time of Death: 9:45 PM
4a. Facility Name (If not institution, give street and number): 2609 MANHATTEN AVE.
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-03-5160
6. Sex: XX 1☑ M 2☐ F
7. Age (In yrs. last birthday): 85 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 2/11/1914
9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 2609 MANHATTEN AVE.
10f. Zip Code: 21215
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☑ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): 2ND CLASS ENGINEER
16b. Kind of Business/Industry: HEATING

17. Father's Name (First, Middle, Last): ABRAHAM CARMEL
18. Mother's Name (First, Middle, Maiden Surname): MARY SMITH

19a. Informant's Name/Relationship (Type, Print): PAULINE CARMEL/ WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2609 MANHATTEN AVE. BALTIMORE, MD. 21215

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ADATH YESHURUN CONGREGATION
Data: 8/16/99
20c. Location - City or Town, State: BALTIMORE MD.

21. Signature of Funeral Service Licensee: Robert D. Levinson
22. Name and Address of Facility: SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Dehydration	1 Week
Due to (or as a consequence of): b.	Dysphagia	1 Week
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last. Due to (or as a consequence of): c.	Parkinson's disease	several years
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Elliot Rothschild MD
29c. License number: D51426
29d. Date signed (Month, Day, Year): Aug. 15, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Elliot Rothschild 4000 Old Court, Pikesville, MD 21208

State Registrar

31. Date filed (Month, Day, Year): AUG 18 1999
32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

A1467

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 25930

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ELIZABETH S. CONNER

2. Date of Death (Month, Day, Year): Aug. 3, 1999

3. Time of Death: 6:00 PM

4a. Facility Name *(If not institution, give street and number)*: Multimedical Nursing Home

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 220-24-4467

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 73 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 6/7/26

9. Birthplace *(State or Foreign Country)*: Kentucky

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore City

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 243-B Rodgers Forge Road

10f. Zip Code: 21212

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): Colleg (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Secretary

16b. Kind of Business/Industry: Education

17. Father's Name *(First, Middle, Last)*: William Kendrick Phillips

18. Mother's Name *(First, Middle, Maiden Surname)*: Elizabeth S. Hardesty

19a. Informant's Name/Relationship *(Type, Print)*: David K. Conner / Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: P.O. Box 702 Moss Landing, California 95039

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Howard U. Coll. of Med.

Date: 8/5/99

20c. Location - City or Town, State: Washington, D.C.

21. Signature of Funeral Service Licensee: Henry O. Robbins

22. Name and Address of Facility: Lincoln & Lincoln Funeral Service 4315 Anacostia Ave., NE Washington, DC 20019

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CARDIOPULMONARY ARREST — --

Due to (or as a consequence of):

b. SEPSIS / ASPIRATION — 48 hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. COPD — Years

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Atrial Fibrillation, Embolis, CVA, Intra Abdominal Abscess

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: A. Shorofsky MD

29c. License number: D 24569

29d. Date signed *(Month, Day, Year)*: 8/6/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): A. Shorofsky, MD 515 Fairmont Ave., Suite 320 Towson, MD 21286

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 18 1999

32. Registrar's Signature: Jennie B. Yates

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25931

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOHN OUTLAW

2. Date of Death: Month 08 Day 14 Year 99

3. Time of Death: 17:58

4a. Facility Name (If not institution, give street and number): BON SECOURS HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: City

Funeral Director

5. Social Security Number: 213-28-7844

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 78 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 29, 1921

9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 3036 Brighton St.

10f. Zip Code: 21216

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer

16b. Kind of Business/Industry: Brickyard

17. Father's Name (First, Middle, Last): Henry Outlaw

18. Mother's Name (First, Middle, Maiden Surname): Lula James

19a. Informant's Name/Relationship (Type, Print): Ms. Dorothy Johnson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 21 N. Catherine St. Balto. Md. 21223

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Garrison Forest

Date: 8/19/99

20c. Location - City or Town, State: Owings Mills, Md.

21. Signature of Funeral Service Licensee: ▶ Joseph L. Russ

22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. ACTIVE TUBERCULOSIS

Due to (or as a consequence of):

b. CACHEXIA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ D Sotirescu M.D.

29c. License number: D 0052909

29d. Date signed (Month, Day, Year): 08/14/1999.

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): DAN SOTIRESCU, BON SECOURS HOSPITAL, E. DEPT., 2000 W BALTIMORE ST

State Registrar

31. Date filed (Month, Day, Year): AUG 18 1999

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

A1441

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25932

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
BARBARA	F.	DuVALL	AUGUST 16, 1999	8:00 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
INDEPENDANT & ASSISTED LIVING OF SEVERNA PARK	SEVERNA PARK	ANNE ARUNDEL

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-42-3542	1☐ M 2☒ F	80 Yrs.			AUG. 9, 1919	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	ANNE ARUNDEL	SEVERN	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1212 PINE CONE COURT	21144	U.S.A.

11. Meritel Stetus	12. Was Decedent Ever in U.S. Armed Forces?	13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)	14. Race - American Indien, Black, White, etc.
1☐ Never Merried 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Yeer or Detes:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grede completed)		16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)		
	2	TEACHER'S AIDE	SCHOOLS

17. Father's Neme (First, Middle, Last)		18. Mother's Neme (First, Middle, Maiden Sumame)	
ALBERT	FRANKLIN	BARBARA	TESAR

19a. Informent's Neme/Reletionship (Type, Print)	19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)
MR. WILLIAM D. DuVALL (HUSBAND)	1212 PINE CONE COURT, SEVERN, MARYLAND 21144

20a. Method of Disposition	20b. Piece of Disposition (Name of cemetery, cremetory or other piece)	Dete	20c. Location - City or Town, Stete
1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)	GLEN HAVEN MEMORIAL PARK	8/19/99	GLEN BURNIE, MARYLAND

21. Signature of Fuperal Service Licensee	22. Neme and Address of Fecility
Paul Hagan	Singleton Funeral Home P.A

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one cause on eech line.

		Approximete Interval Between Onset and Death
Immediete Cause (Finel diseese or condition resulting in deeth)	a. Pneumonia	days
Due to (or es a consequence of):	b. cerebrovascular accident	weeks
Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in death) Lest	Due to (or es e consequence of): c.	
	Due to (or es a consequenca of): d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Alzheimers Disease

23b. Did tobecco use contributa to the causa of death?	24a. Wes an autopsy performed?	24b. Were eutopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown	1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Wes case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Assisted Living

27. Menner of Death	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) end menner as stated.
2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and menner steted.

29b. Signeture and title of certifier	29c. License number	29d. Dete signed (Month, Dey, Year)
	D41955	8-17-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Rebecca Eton MD 479 Jumpers Hole Rd Severna Park MD 21146

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
AUG 18 1999	Jennie G. Spatal

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25933

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Anita Fenwick

2. Date of Death: Month August Day 10, Year 1999

3. Time of Death: 5 30 AM

4a. Facility Name (If not institution, give street and number): Mercy Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: n/a

Funeral Director

5. Social Security Number: 216-80-6827

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 37 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): October 4, 1961

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: n/a

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2826 Windsor Avenue

10f. Zip Code: 21216

10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: African-American

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): silk screen printer

16b. Kind of Business/Industry: silk screen

17. Father's Name (First, Middle, Last): Raymond Fenwick

18. Mother's Name (First, Middle, Maiden Surname): Natalie Butler

19a. Informant's Name/Relationship (Type, Print): Zakyyah Wilson - daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2826 Windsor Avenue, Baltimore, Maryland 21216

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Loudon Park Cemetery

Date: 8/17/99

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Ann Y. Zink

22. Name and Address of Facility: Loudon Park Funeral Home, 3620 Wilkens Avenue, Baltimore, Maryland 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Metastatic Breast Cancer — 4 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Stella Maris at Mercy Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]

29c. License number: D40854

29d. Date signed (Month, Day, Year): August 10, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID RISEBERG 301 St Paul Pl, Baltimore, MD 21202

State Registrar

31. Date filed (Month, Day, Year): AUG 18 1999

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
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Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

AH3

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND #19a PER F.H. G774 8-18-99 J.A.

Certificate of Death

Reg. No. 99 25934

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last): Lizzie Fobbs
2. Date of Death (Month, Day, Year): AUGUST 15 1999
3. Time of Death: 1:30pm
4a. Facility Name (If not institution, give street and number): 2403 West North Ave
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: NA
5. Social Security Number: 246-66-1085
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 59 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 08 05 40
9. Birthplace (State or Foreign Country): N.C.

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 2403 West North Ave
10f. Zip Code: 21216
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th grade; College (1-4or 5+): na
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Attendant
16b. Kind of Business/Industry: Laundromat
17. Father's Name (First, Middle, Last): Ben Fobbs
18. Mother's Name (First, Middle, Maiden Surname): Mattie Hasco
19a. Informant's Name/Relationship (Type, Print): LUCILLE ~~Lucilla~~ Lynch-Cousin
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1800 Braddish Ave, Baltimore Md 21216
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Bear Swamp Church Cem.
Date: 8/21/99
20c. Location - City or Town, State: Littleton, N.C.
21. Signature of Funeral Service Licensee: Rome H. Thompson
22. Name and Address of Facility: March F/H West 4300 Wabash Ave, Baltimore Md 21215

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ACUTE MYOCARDIAL INFARCTION — 0 day

Due to (or as a consequence of):
b. CORONARY ARTERY DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Frederick Kuhn MD
29c. License number: 036336
29d. Date signed (Month, Day, Year): August 17, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): FREDERICK KUHN MD 3449 Wilkens Ave #300 Baltimore MD

State Registrar

31. Date filed (Month, Day, Year): AUG 18 1999
32. Registrar's Signature: Barbara B. Sparks

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25935

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LOUIS FRIEMAN

2. Date of Death: Month August Day 15 Year 1999

3. Time of Death: 2:25 pm

4a. Facility Name (If not institution, give street and number): Sinai Hospital of Baltimore

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-03-2557

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): SEPT 25, 1913

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10a. Street and Number: 7502 BROOKCREST ROAD #T-2

10f. Zip Code: 21208

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indien, Bleck, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SALESMAN

16b. Kind of Business/Industry: CARPETING

17. Fether's Name (First, Middle, Last): SAMUEL FRIEMAN

18. Mother's Name (First, Middle, Maiden Surname): ANNA EPSTEIN

19e. Informant's Name/Relettionship (Type, Print): SARAH FRIEMAN / WIFE

19b. Mailing Address (Street and Number or Rural Route Number, Cify or Town, State, Zip Code): 7502 BROOKCREST ROAD #T-2, BALTIMORE, MD 21208

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): BETH EL MEMORIAL PARK

Date: 8/17/99

20c. Location - City or Town, State: RANDALLSTOWN, MD

21. Signature of Funeral Director: [signature]

22. Name end Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Sepsis leading to cardiopulmonary arrest

Due to (or as e consequence of):

Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequenca of):

d.

Part ii. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert i.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residenca 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end menner stated.

29b. Signature and title of certifier: Arthur Li, MD

29c. License number: RES-000

29d. Date signed (Month, Day, Year): August 15 1999

30. Neme and eddress of person who completed cause of death (Item 23a) (Type, Print): Arthur Li, Sinai Hospital of Baltimore

State Registrar

31. Date filed (Month, Day, Year): AUG 18 1999

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physicien end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Friemen, Louis

A46+1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25936

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Agnes Bernadette Gurinskas
2. Date of Death: Month August Day 16 Year 1999
3. Time of Death: 10 35
4a. Facility Name (If not institution, give street and number): St. Agnes Healthcare
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: n/a

Funeral Director

5. Social Security Number: 219-18-6932
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 16, 1924
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: n/a
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 540 Beechfield Avenue
10f. Zip Code: 21229
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 3
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): registered nurse
16b. Kind of Business/Industry: hospital

17. Father's Name (First, Middle, Last): Joseph Valeika
18. Mother's Name (First, Middle, Maiden Surname): Gertrude Zelinskas

19a. Informant's Name/Relationship (Type, Print): Chester Valeika - brother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 601 Warwick Road, Baltimore, Maryland 21229

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Loudon Park Cemetery
Date: 8/20/99
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Ann Y. Zink
22. Name and Address of Facility: Loudon Park Funeral Home, 3620 Wilkens Avenue, Baltimore, Maryland 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE — 10 DAYS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CONGESTIVE HEART FAILURE

RHEUMATOID ARTHRITIS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ MEDICAL DOCTOR
29c. License number: 012597
29d. Date signed (Month, Day, Year): August 16, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): WOLALI NUTAKOR, 900 CATON AVE, BALTIMORE, MD 21229

State Registrar

31. Date filed (Month, Day, Year): AUG 18 1999
32. Registrar's Signature: Denise G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME Gurinskas, Agnes
Division of Vital Records, P.O. Box 68760,

9174

AMENDED ITEM #3 PER MD G774 8/20/99 AH
AMEND#2 8-18-99 J.A.

99-25937

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

AMEND#1 PER MD. #10e & 19b PER F.H. G774

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ~~TAVON~~ TEVON GRAY GREENE II

2. Date of Death: Month ~~8~~ Day ~~11~~ Year ~~99~~ 8-11-99

3. Time of Death: ~~11:28 PM~~ 2:25am

4a. Facility Name (If not institution, give street and number): MERCY MEDICAL CENTER

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death:

Funeral Director

5. Social Security Number: NA

6. Sex: 1 X M 2 ☐ F

7. Age (In yrs. last birthday): Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours 3 / Min.

8. Date of Birth (Month, Day, Year): 8 10 99

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: —

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 X Yes 2 ☐ No

10e. Street and Number: ~~801 PRESSMAN ST.~~ 1801 PRESSTMAN STREET

10f. Zip Code: 21217

10g. Citizen of What Country? USA

11. Marital Status: 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yas 2 X No If Yes, Give Yaar or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 1 ☐ Yes 2 X No Specify:

14. Race - Americen Indian, Black, White, atc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondary (0-12): NA

College (1-4or 5+): NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): NEWBORN

16b. Kind of Business/Industry: NA

17. Father's Nama (First, Middle, Last): Tevon c. Gray

18. Mother's Name (First, Middle, Maiden Surname): Jessica Greene

19a. tnformant's Name/Reletionship (Type, Print): Grand-Mother Cynthia Matthews Greens

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 1801 ~~Preesman~~ PRESSTMAN Street, Baltimore Md 21217

20a. Method of Disposition: 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other piece): Metro Crematory Inc

Date: 8/16/99

20c. Location - City or Town, State: Baltimore, Md

21. Signature of Funeral Service Licensee: Frome A. Thompson

22. Name and Address of Facility: March F/H West 4300 Wabash Ave, Baltimore Md 21215

Physician /Medical Examiner

23a. Part I. Enter the diseasa, or complications that caused the death. Do not enter the moda of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. EXTREME PREMATURITY — 3 HOURS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: CHORIOAMNIONITIS

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings availabia prior to completion of causa of deeth? 1 ☐ Yes 2 ☐ No

25. Was case referred to medicel examiner? 1 ☐ Yes 2 X No

26. Place of Death (Check only one): Hospitel: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Menner of Deeth: 1 X Natural 2 ☐ Accident 3 ☐ Suicida 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 X **Certifying Phyatctan:** To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner es steted. 2 ☐ **Medtcat Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piace, end due to the cause(s) and mannar stated.

29b. Signature and title of certifier: ▶ Ronald J. Gutberlet, M.D.

29c. License number: D03588

29d. Date signed (Month, Day, Year): 8/13/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): RONALD L. GUTBERLET, M.D. - MERCY MEDICAL CNTR.

State Registrar

31. Dete filed (Month, Day, Year): AUG 18 1999

32. Registrar's Signature: Bernice G. Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To be Completed by Funeral Director

permit. Pages 1 end 2 should be filed within 72 hours after death with the Meryland Department of Haalth and Mentel Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other trauamatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND #10e&20b PER F.H. G774 8-18-99 J.A. **Certificate of Death** Reg. No. 99 25938

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jessie Greene
2. Date of Death Month/Day/Year: August 13, 1999
3. Time of Death: 1PM
4a. Facility Name (If not institution, give street and number): Genesis Eldercare Caton Manor
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death:

Funeral Director

5. Social Security Number: 225-22-8472
6. Sex: 1☐ M XX F
7. Age (In yrs. last birthday): 94 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 04 26 05
9. Birthplace (State or Foreign Country): V.A.

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4509 ~~45099~~ Umatilla Ave
10f. Zip Code: 21215
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7th grade | College (1-4 or 5+): na
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Farm Worker
16b. Kind of Business/Industry: Unknown
17. Father's Name (First, Middle, Last): Jesse Porter
18. Mother's Name (First, Middle, Maiden Surname): Elmarada Purdie
19a. Informant's Name/Relationship (Type, Print): Selma Guion-Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4509 Umatilla Ave, Baltimore Md 21215
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MT. ZION CEMETERY ~~King Memorial Park~~ Date: 8/19/99
20c. Location - City or Town, State: Randallstown, Md
21. Signature of Funeral Service Licensee: Jerome A. Thompson
22. Name and Address of Facility: March F/H West 4300 Wabash Ave, Baltimore Md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Cerebrovascular Accident
Due to (or as a consequence of): b. Atherosclerotic Cardiovascular disease
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of): c.
Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hypertensive artery disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 8☐ Other (Specify)
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Deeds
29c. License number: D17537
29d. Date signed (Month, Day, Year): 8.13.99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DARSHAN S. SALUJA 1600 W. MOUNT Royal Ave, Balto 21217

State Registrar

31. Date filed (Month, Day, Year): AUG 18 1999
32. Registrar's Signature: Denise S. Spicer

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Jessie Greene

AHD

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25939

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: OCAM GRAY
2. Date of Death — Month: August Day: 14 Year: 1999
3. Time of Death: 15:30
4a. Facility Name *(If not institution, give street and number)*: MERCY HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 213 16 3994
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 90 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: March 24 1909
9. Birthplace *(State or Foreign Country)*: NC

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1129 Harford Avenue
10f. Zip Code: 21202
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): High Sch. Grad — College (1-4or 5+): NA
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Key Highway
16b. Kind of Business/Industry: Bethlehem Steel Co.

17. Father's Name *(First, Middle, Last)*: Arthur Gray
18. Mother's Name *(First, Middle, Maiden Surname)*: Betty L. Cotton

19a. Informant's Name/Relationship *(Type, Print)*: Gregory Gray
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 85 E. 10th Street New York, NY 10003

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Arbutus Mem. Gardens — Date: 08-19-99
20c. Location - City or Town, State: Arbutus, MD

21. Signature of Funeral Service Licensee: Gloria M. Davis
22. Name and Address of Facility: Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the *mode* of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Stroke	3 days
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] MD
29c. License number: D0054620
29d. Date signed *(Month, Day, Year)*: August 14 1999
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Lawrence J. McDermott, MD Mercy Hospital

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 18 1999
32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

94-7

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25940

7:31 pm 8/16/99 Benjamin Gentry Baltimore, Maryland 21215-0020

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Benjamin F. Gentry
2. Date of Death (Month, Day, Year): August 16, 1999
3. Time of Death: 7:31 PM
4a. Facility Name (If not institution, give street and number): Gilchrist Center for Hospice Care GBMC
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 217-01-4512
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 19, 1910
9. Birthplace (State or Foreign Country): Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1936 Ormand Road
10f. Zip Code: 21222
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 5 Years | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Boilermaker
16b. Kind of Business/Industry: Shipyard Steel Industry

17. Father's Name (First, Middle, Last): Tobias Gentry
18. Mother's Name (First, Middle, Maiden Surname): Cora B. Not Known

19a. Informant's Name/Reletionship (Type, Print): Phyllis M. Bosche / Daughter
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code): 8128 North Boundary Road Dundalk, Maryland 21222

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Oak Lawn Cemetery
Date: 8/20/1999
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Chas W. Ruck
22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or raspiratory arrest, shock, or heart failura. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final diseese or condition resulting in death): a. CAncer of the Lung — months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were eutopsy findings availeble prior to compiation of causa of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) Hospice
27. Manner of Death: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner es steted. 2 [ ] **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end piece, end due to the cause(s) and manner stated.

29b. Signature and Title of certifier: W. Anthony Riley, MD
29c. License number: D25205
29d. Date signed (Month, Day, Year): August 17, 1999

30. Name end address of person who completed cause of death (Item 23b) (Type, Print): W.A. Riley GBMC 6701 N. Charles St. Balto. Md 21204

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Dey, Year): AUG 18 1999
32. Registrar's Signature: [illegible] B. Sparks

DHMH 16 Rev 6/95

AF/10

99-4659-510
CJ
Michael Francis Geffken

AMEND ITEM: #23 PART I PER MEO G775 9-24-99 WR
AMEND ITEMS: #23 PART I, 27, 28A-F PER MEO G774 8-27-99 WR.
AMEND#5 PER F.H. G774 8-20-99 J.A.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25941

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Data of Death Month	Day	Year	3. Time of Death
Michael Francis Geffken	August	11	1999	12:30 PM.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
3600 Pulaski Highway Apt. #304	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Data of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
~~118-11-9811~~ 115-36-9811	1☐ M 2☒ F	47 Yrs.			Jan. 27, 1952	Brooklyn NewYork

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Florida	Broward	Tamarac	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
11010 Bailey Lane	33321	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	2	Owner	Automobile Transmission

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Frank Geffken	Mary Abbatte

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Christine Geffken Wife	11010 Bailey Lane Tamarac, Florida 33321

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place) Date	20c. Location - City or Town, State
1☐ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)	August 20, 1999 Queen of Heaven Mausoleum	N. Lauderdale, Fla.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Michael L. Bigler	Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)	a. NARCOTIC & COCAINE INTOXICATION ~~NARCOTIC INTOXICATION~~	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒ Yes 2☐ No	1☒ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒ Yes 2☐ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Scene

27. Manner of Death	28a. Data of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☒ Could not be determined	FOUND: 8-11-99	UNKNOWN M	1☐ Yes 2☒ No	UNKNOWN

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
FOUND IN MOTEL	3600 PULASKI HWY., BALTIMORE, MD

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier	29c. License number	29d. Data signed (Month, Day, Year)
[signature]	O.C.M.E.	August 12, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Fulton Wake, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
AUG 18 1999	Geneva G. Sparks

DHMH 16 Rev 6/95

AH

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 25942

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ADELE G. HURWITZ

2. Date of Death (Month, Day, Year): August 13, 1999

3. Time of Death: 12:40am

4a. Facility Name (If not institution, give street and number): Sinai Hospital of Baltimore

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

Funeral Director

5. Social Security Number: 218-26-6531

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 67 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): DEC. 15, 1931

9. Birthplace (State or Foreign Country): NY

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2500 W. BELVEDERE AVE. #520

10f. Zip Code: 21215

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOUSEWIFE

16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): BERT KATZ

18. Mother's Name (First, Middle, Maiden Surname): SARAH MACHLIS

19a. Informant's Name/Relationship (Type, Print): JEROME HURWITZ / HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2500 W. BELVEDERE AVE. #520 - BALTIMORE, MD 21215

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): SWINICHER WOLINER BENEV. SOC.

Date: 8/15/99

20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee:

22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Sepsis
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Insulin Dependent Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: P 13214

29d. Date signed (Month, Day, Year): 8/13/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Chris Ha 2401 W. Belvedere Ave. Baltimore, MD 21215

State Registrar

31. Date filed (Month, Day, Year): AUG 18 1999

32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Adele Hurwitz

A45

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25943

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DEBBIE HARRIS

2. Date of Death: Month August Day 16 Year 1999

3. Time of Death: 10:17 AM

4a. Facility Name (If not institution, give street and number): UNIVERSITY OF MARYLAND HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE CITY

4c. County of Death: BALTIMORE CITY

Funeral Director

5. Social Security Number: 214-74-6488

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 40 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): NOV 30 1958

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: BALTIMORE

10c. City, Town or Location: COCKEYSVILLE

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 409 LAKEVISTA CIRCLE APT J

10f. Zip Code: 21030

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 yrs | College (1-4or 5+): 2 yrs

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SENIOR CLAIM REP

16b. Kind of Business/Industry: INSURANCE

17. Father's Name (First, Middle, Last): EDISON JAMES

18. Mother's Name (First, Middle, Maiden Surname): FRANKIE RICHBURG

19a. Informant's Name/Relationship (Type, Print): Rodney G. Harris/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 409 LakeVista Circle Apt J. Cockeysville, MD 21030

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): DULANEY VALLEY MEM GAR.

Date: 8-20-99

20c. Location - City or Town, State: DULANEY VALLEY, MD

21. Signature of Funeral Service Licensee: Barbara A. Dixon

22. Name and Address of Facility: WILLIAM C BROWN COMMUNITY FUNERAL HOME PA
1206 W NORTH AVENUE

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardiac arrest
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. myocardial infarction
Due to (or as a consequence of):
c. Right Lung transplant
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Interstitial pulmonary fibrosis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Lisa Nyikan

29c. License number: P12456

29d. Date signed (Month, Day, Year): August 16, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 22 South Greene Street Baltimore, MD

State Registrar

31. Date filed (Month, Day, Year): AUG 18 1999

32. Registrar's Signature: Barbara G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

16

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99-25944

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Nancy Louise Hardiman

2. Date of Death: Month: August Day: 15th Year: 1999

3. Time of Death: 1.05 am

4a. Facility Name (If not institution, give street and number): Stella Maris Hospice

4b. City, Town, or Location of Death: Baltimore County

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 213-38-5096

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 60 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): December 2, 1938

9. Birthplace (State or Foreign Country): Baltimore City, Md.

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore City

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3639 Chesterfield Avenue

10f. Zip Code: 21213

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife

16b. Kind of Business/Industry: Housekeeping-Own Home

17. Father's Name (First, Middle, Last): Clyde Miller

18. Mother's Name (First, Middle, Maiden Surname): Elizabeth Hurst Campbell

19a. Informant's Name/Relationship (Type, Print): Marvin H. Hardiman (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3639 Chesterfield Avenue Baltimore, Maryland 21213

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Gardens of Faith Cem. Date: August 17, 1999

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Lassahn Funeral Home, Inc. 7401 Belair Road Baltimore, Maryland 21236-4625

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Breast Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D43725

29d. Date signed (Month, Day, Year): 8/16/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): TARIQ MAHMOOD 201-109 Back River Neck Road Baltimore MD 21221

State Registrar

31. Date filed (Month, Day, Year): AUG 18 1999

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Nancy Hardiman

AT6

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25945

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: RICHARD JOHNSON

2. Date of Death — Month: AUGUST Day: 12 Year: 1999

3. Time of Death: 450 PM

4a. Facility Name *(If not institution, give street and number)*: SINAI HOSPITAL OF BALTIMORE

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 241-54-5654

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 59 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: JAN 19, 1940

9. Birthplace *(State or Foreign Country)*: N.C.

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 3808 Pinkney Road

10f. Zip Code: 21215

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10th — College (1-4or 5+): N/A

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: TRUCK DRIVER

16b. Kind of Business/Industry: Hollenshade's Inc

17. Father's Name *(First, Middle, Last)*: TRACEY JOHNSON

18. Mother's Name *(First, Middle, Maiden Surname)*: REGINA MOORE

19a. Informant's Name/Relationship *(Type, Print)*: Georgia M. Johnson - wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3808 Pinkney Road Balto. Md. 21215

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Loudon Park Cem — Date: 8/18/99

20c. Location - City or Town, State: Balto. MD

21. Signature of Funeral Service Licensee: Wayne B. Harris

22. Name and Address of Facility: March Funeral Home West, Inc. 4300 Wabash Ave. Balto. Md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
- e. PNEUMONIA — SIX HOURS

Due to (or as a consequence of):
- b. ACUTE PULMONARY EDEMA — SIX HOURS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
- c. CHRONIC RENAL FAILURE

Due to (or as a consequence of):
- d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Fred B Sunness MD

29c. License number: D29250

29d. Date signed *(Month, Day, Year)*: 8-12-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): FRED B SUNNESS MD

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 18 1999

32. Registrar's Signature: Bonnie B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

A14 10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25946

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): D. VIRGINIA JONES

2. Date of Death: Month AUGUST Day 14th Year 1999

3. Time of Death: 8.00 AM

4a. Facility Name (If not institution, give street and number): MARINER HEALTH OF NORTH ARUNDEL

4b. City, Town, or Location of Death: GLEN BURNIE

4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 578-18-4167

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 1/30/1916

9. Birthplace (State or Foreign Country): Georgia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Glen Burnie

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 319 New Jersey Avenue

10f. Zip Code: 21060

10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4 or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Distributor

16b. Kind of Business/Industry: Vanda Beauty Counselor

17. Father's Name (First, Middle, Last): Arthur Cheek

18. Mother's Name (First, Middle, Maiden Surname): Mabel Singleton

19a. Informant's Name/Relationship (Type, Print): Hugh H. Jones, IV (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8329 Sail Ct. Pasadena, Maryland 21122

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Maryland Veteran Cemetery

Date: 8/17 1999

20c. Location - City or Town, State: Crownsville, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Singleton Funeral Home PA, 1 Second Avenue S.W. Glen Burnie, MD 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Acute Respiratory Acidosis	2 weeks
Due to (or as a consequence of): b.	Non Small Cell Cancer of Lung	2 weeks
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	Chronic Obstructive Pulmonary Disease	Many Years
d.	Chronic Smoking	Many Years

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hypertension

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: L. Jassi M. D.

29c. License number: D0054292

29d. Date signed (Month, Day, Year): August 14th 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SUKHPAL JASSI, 1600 CRAIN HIGHWAY, SUITE 201, GLEN BURNIE, MD 21061

State Registrar

31. Date filed (Month, Day, Year): AUG 18 1999

32. Registrar's Signature: [signature]

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: 8 PER F.H. G774 8-25-99 WR.

Certificate of Death

Reg. No. 99 25947

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EDGAR KRONENBERGER
2. Date of Death Month: AUGUST Day: 14 Year: 1999
3. Time of Death: 0840
4a. Facility Name (If not institution, give street and number): NORTHWEST HOSPITAL
4b. City, Town, or Location of Death: RANDALLSTOWN
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 060-26-1377
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 7/28/21 (7/27/1921)
9. Birthplace (State or Foreign Country): GERMANY

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: OWINGS MILLS
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 9903 MIDDLE MILL DRIVE
10f. Zip Code: 21117
10g. Citizen of What Country?: USA
11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): PLUMBER
16b. Kind of Business/Industry: PLUMBING
17. Father's Name (First, Middle, Last): ALBERT KRONENBERGER
18. Mother's Name (First, Middle, Maiden Surname): ELIZABETH ISAAC
19a. Informant's Name/Relationship (Type, Print): REGINA KRONENBERGER/WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9903 MIDDLE MILL DR. OWINGS MILLS, MD. 21117
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): BALTIMORE HEBREW
Date: 8/15/99
20c. Location - City or Town, State: REISTERSTOWN MD.
21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD. 21208

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. SEPSIS
Due to (or as a consequence of):
b. ACUTE RENAL FAILURE
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: CANDIDA ESOPHAGITIS

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: HOUSE STAFF
29c. License number: D 40390
29d. Date signed (Month, Day, Year): AUGUST 14, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): P.RADESAH, MD; C/O NW HOSPITAL, 5401 OLD COURT RD, RANDALLSTOWN MD 21133

State Registrar

31. Date filed (Month, Day, Year): AUG 18 1999
32. Registrar's Signature: Regina G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

8/18

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEM #23a & #25 PER MD G774 8/18/99 AH

Certificate of Death

Reg. No. 99 25948

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): O. C. KELLEY

2. Date of Death (Month, Day, Year): JULY 6, 1999

3. Time of Death: 9:44P.M.

4a. Facility Name (If not institution, give street and number): PRINCE GEORGE'S HOSPITAL CENTER

4b. City, Town, or Location of Death: CHEVERLY

4c. County of Death: PRINCE GEORGE'S

Funeral Director

5. Social Security Number: 257-44-8014

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 75 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 2,1924

9. Birthplace (State or Foreign Country): GA

Usual Residence of Decedent

10a. State: D.C.

10b. County: --

10c. City, Town or Location: Washington

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 4425 A St., N.E. #101

10f. Zip Code: 20019

10g. Citizen of What Country? United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Construction

16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): Richard Kelley

18. Mother's Name (First, Middle, Maiden Surname): Sular Surency Kelley

19a. Informant's Name/Relationship (Type, Print): Karen Kelly/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2407 Southern Ave. #301 Temple Hills, Md 20748

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): Forest Hills Cemetery

Date: 7-12-99

20c. Location - City or Town, State: Clinton, Md.

21. Signature of Funeral Service Licensee: ▶ Shawn Thurman Talley

22. Name and Address of Facility: Capitol Mortuary 1425 Maryland Ave., NE Wash., DC 20002

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. CARDIOPULMONARY ARREST.

Due to (or as a consequence of):
ACUTE RESPIRATORY DISTRESS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

THROAT CARCINOMA

TRACHEOSTOMY.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☑ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Anil K. Mahajan MD

29c. License number: D50689.

29d. Date signed (Month, Day, Year): 07/06/1999.

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): ANIL K MAHAJAN P.G.HOSPITAL 8D.3001 HOSPITAL DRIVE CHEVERLY MD.

State Registrar

31. Date filed (Month, Day, Year): AUG 18 1999

32. Registrar's Signature: Donna B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25949

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LEE LEON LEBOWITZ
2. Date of Death (Month, Day, Year): August 12, 1999
3. Time of Death: 9:25pm
4a. Facility Name (If not Institution, give street and number): Sinai Hospital of Baltimore
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 064-18-5284
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 76 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): APR. 9, 1923
9. Birthplace (State or Foreign Country): NY

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 3500 TRAINOR AVENUE
10f. Zip Code: 21215
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII NAVY
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): PROPRIETOR
16b. Kind of Business/Industry: SHERLOCK SECURITY INC.

17. Father's Name (First, Middle, Last): JACOB LEBOWITZ
18. Mother's Name (First, Middle, Maiden Surname): ANNA FINKELSTEIN

19a. Informant's Name/Relationship (Type, Print): MIRIAM LEBOWITZ / WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3500 TRAINOR AVENUE - BALTIMORE, MD 21215

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MD VETERANS CEMETERY
Date: 8/16/99
20c. Location - City or Town, State: OWINGS MILLS, MD

21. Signature of Funeral Service Licensee: ▶ Scott M. Cutler
22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediete Cause (Finel disease or condition resulting in death)
a. Bladder Cancer — years

Due to (or as a consequence of):

b. Lung Metastasis — years

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Lest

Due to (or es a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Christopher Davis
29c. License number: UMP 11227
29d. Date signed (Month, Day, Year): August 13, 1999

30. Name end address of person who completed cause of death (Item 23a) (Type, Print): Christopher Davis 2401 West Belvedere Avenue Baltimore, Maryland 21215

State Registrar

31. Date filed (Month, Day, Year): AUG 18 1999
32. Registrar's Signature: Barbara B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Lee Lebowitz

AH6T1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25950

Levin, Joseph
Baltimore, Maryland 21215-0020

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOSEPH E. LEVIN
2. Date of Death (Month, Day, Year): August 13 1999
3. Time of Death: 8:17am
4a. Facility Name (If not institution, give street and number): Sinai Hospital of Baltimore
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-01-1004
6. Sex: [X] M [ ] F
7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): NOV. 4, 1918
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: RANDALLSTOWN
10d. Inside City Limits: [ ] Yes [X] No
10e. Street and Number: 3915 CHAFFEY ROAD
10f. Zip Code: 21133
10g. Citizen of What Country?: U.S.A.

11. Marital Status: [ ] Never Married [ ] Married [X] Widowed [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? [X] Yes [ ] No — If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): [ ] Yes [X] No — Specify:
14. Race - American Indian, Black, White, etc. — Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SALESMAN
16b. Kind of Business/Industry: HARDWARE

17. Father's Name (First, Middle, Last): JACOB LEVIN
18. Mother's Name (First, Middle, Maiden Surname): MARY LEVIN

19a. Informant's Name/Relationship (Type, Print): STANTON LEVIN / SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13 POMONA SOUTH #5 - BALTIMORE, MD 21208

20a. Method of Disposition: [X] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): BETH TFILOH CEMETERY
Date: 8/15/99
20c. Location - City or Town, State: WOODLAWN, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Anoxic encephalopathy secondary to asystolic arrest
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? [ ] Yes [ ] No [ ] Probably [X] Unknown

24a. Was an autopsy performed? [ ] Yes [X] No
24b. Were autopsy findings available prior to completion of cause of death? [ ] Yes [ ] No

25. Was case referred to medical examiner? [ ] Yes [X] No

26. Place of Death (Check only one): Hospital: [X] Inpatient [ ] ER/Outpatient [ ] DOA — Other: [ ] Nursing Home [ ] Residence [ ] Other (Specify)

27. Manner of Death: [X] Natural [ ] Accident [ ] Suicide [ ] Homicide [ ] Pending investigation [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury: M
28c. Injury at Work? [ ] Yes [ ] No
28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

29a. Certifier (Check only one): [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: RES-000
29d. Date signed (Month, Day, Year): August 13 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Arthur Li, MD, Sinai Hospital of Baltimore

State Registrar

31. Date filed (Month, Day, Year): AUG 18 1999
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

AH 2071

99-4735-510
jhm
BRIAN
LOHN

AMEND ITEMS: #23 PART I, 27, 28A-F PER MEO G774

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

8-27-99 WR.

Certificate of Death

99 25951
Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BRIAN DAVID LOHN
2. Date of Death (Month, Day, Year): AUGUST 16, 1999
3. Time of Death: 03:50 AM
4a. Facility Name (If not institution, give street and number): 3423 FOSTER AVE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 220-88-5128
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 37 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): NOV. 3, 1961
9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD.
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 3423 FOSTER AVE.
10f. Zip Code: 21224
10g. Citizen of What Country: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SHEET METAL
16b. Kind of Business/Industry: CONSTRUCTION

17. Father's Name (First, Middle, Last): FREDERICK C. LOHN
18. Mother's Name (First, Middle, Maiden Surname): VERNA L. FORD

19a. Informant's Name/Relationship (Type, Print): FREDERICK C. LOHN/FATHER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2929 W. ALMONDBURY DR., PASADENA, MD. 21122

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): OAK LAWN CEMETERY
Date: 8/19/99
20c. Location - City or Town, State: BALTIMORE, MD.

21. Signature of Funeral Service Licensee: Elizabeth Jelenski
22. Name and Address of Facility: CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVE. BALTIMORE, MD. 21224

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. NARCOTIC AND ALCOHOL INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [X] Could not be determined
28a. Date of Injury (Month, Day Year): FOUND: 8-16-99
28b. Time of Injury: UNKNOWN M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: UNKNOWN
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): HOUSE
28f. Location (Street and Number or Rural Route Number, City or Town, State): 3423 FOSTER AVE, BALTIMORE, MD

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: OCME
29d. Date signed (Month, Day, Year): AUGUST 16, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JASON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): AUG 18 1999
32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

AH

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25952

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: John M. Landis
2. Date of Death Month / Day / Year: August 16 1999
3. Time of Death: 6:25PM
4a. Facility Name *(If not institution, give street and number)*: College Manor Nursing Home
4b. City, Town, or Location of Death: Lutherville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 204-03-3912
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: May 22 1911
9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: MD.
10b. County: Harford
10c. City, Town or Location: White Hall
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 4762 Carea Rd.
10f. Zip Code: 21161
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Machinist
16b. Kind of Business/Industry: Industrial

17. Father's Name *(First, Middle, Last)*: Clayton Landis
18. Mother's Name *(First, Middle, Maiden Surname)*: Alice Miller

19a. Informent's Name/Relationship *(Type, Print)*: Mrs. Barbara Ensor/Granddaughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4762 Carea Rd. White Hall, MD. 21161

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Woodlawn Mem. Gdns. | Date: 8-20-99
20c. Location - City or Town, State: Harrisburg, Pa.

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, MD. 21204

Physician /Medical Examiner

23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Cardiopulmonary Arrest	10 min.
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Metastatic Colon Cancer	6 mos.
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ William D. McConnell MD
29c. License number: D42129
29d. Date signed *(Month, Day, Year)*: Aug. 17, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William D. McConnell M.D. 500 W. University Baltimore

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 18 1999
32. Registrar's Signature: [signature] G. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

A410

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25953

Certificate of Death Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: David Allen Lester
2. Date of Death Month / Day / Year: Aug 16 1999
3. Time of Death: 0750
4a. Facility Name *(If not institution, give street and number)*: Cromwell Elementary School
4b. City, Town, or Location of Death: Ferndale
4c. County of Death: AA

Funeral Director

5. Social Security Number: 220-70-0092
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 40 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: JULY 8, 1959
9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: CECIL
10c. City, Town or Location: RISING SUN
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 303 SUNRISE CIRCLE
10f. Zip Code: 21911
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE
15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: FLEET MANAGER
16b. Kind of Business/Industry: CAR RENTAL
17. Father's Name *(First, Middle, Last)*: DAVID JOHNSON LESTER
18. Mother's Name *(First, Middle, Maiden Surname)*: DOROTHY A. RING
19a. Informant's Name/Relationship *(Type, Print)*: BRENDA L. LESTER/ WIFE
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 303 SUNRISE CIRCLE, RISING SUN, MD 21911
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: GLEN HAVEN MEM. PK.
Date: AUG. 20 1999
20c. Location - City or Town, State: GLEN BURNIE, MARYLAND
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: KIRKLEY-RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Finel disease or condition resulting in death): a. Shotgun Wound Head — Immediate

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other *(Specify)* School

27. Manner of Death: 1 [ ] Neturel 2 [ ] Accident 3 [X] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*: 8/16/99
28b. Time of Injury: 0740 M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: Shot Self.
28e. Piece of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*: School
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: Ferndale, MD.

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner**: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date end pleca, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier: [signature] Deputy MD
29c. License number: D06054
29d. Date signed *(Month, Day, Year)*: 8/16/99

30. Neme and address of person who completed cause of death (Item 23e) (Type, Print): William P. Jones, MD 695 America 21035

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 18 1999
32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ADH
MARTIN L. LEACH
99-4675-510
AMEND ITEMS: #23 PART I, 27 PER MEO G774 8-30-99 WR.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25954

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARTIN LUTHER LEACH
2. Date of Death (Month, Day, Year): AUGUST 12, 1999
3. Time of Death: 1722 PM
4a. Facility Name (If not institution, give street and number): JOHNS HOPKINS HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-86-2443
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 35 Yrs. (If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.)
8. Date of Birth (Month, Day, Year): DEC 7 1963
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1512 MEDFORD ROAD
10f. Zip Code: 21218
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10th grade; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LABORER
16b. Kind of Business/Industry: HANDYMAN

17. Father's Name (First, Middle, Last): NATHANIEL LEACH SR.
18. Mother's Name (First, Middle, Maiden Surname): SHIRLEY HOPKINS

19a. Informant's Name/Relationship (Type, Print): Shirley D. Leach/Mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1512 Medford Road, Baltimore, Maryland 21218

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): VOSHELL MEMORIAL GARDENS
Date: 8-19-99
20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: Barbara A Brown
22. Name and Address of Facility: WILLIAM C BROWN COMMUNITY FUNERAL HOME PA
1206 W NORTH AVENUE

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. BRONCHIAL ASTHMA
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: J Pestaner, M.D.
29c. License number: OCME
29d. Date signed (Month, Day, Year): AUGUST 13, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): AUG 18 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25955

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: James McKay

2. Date of Death Month: August Day: 12 Year: 1999

3. Time of Death: 0946am

4a. Facility Name *(If not institution, give street and number)*: Villa St. Michael N/H

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: NA

Funeral Director

5. Social Security Number: 214-44-8221

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 52 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 08 26 46

9. Birthplace *(State or Foreign Country)*: M.D.

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 2508 Loyola Northway

10f. Zip Code: 21215

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [XX] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8th grade; College (1-4or 5+): na

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Home Improvement

16b. Kind of Business/Industry: Private

17. Father's Name *(First, Middle, Last)*: Frank McKay

18. Mother's Name *(First, Middle, Maiden Surname)*: Ethel B. Ingram

19a. Informant's Name/Relationship *(Type, Print)*: Frank McKay Jr.

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3800 W. Belvedere Apt 721 Baltimore Md 21215

20a. Method of Disposition: 1 [ ] Burial 2 [XX] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metro Crematory Inc

Date: 8/20/99

20c. Location - City or Town, State: Baltimore, Md

21. Signature of Funeral Service Licensee: Lynette K. Jones

22. Name and Address of Facility: March F/H West 4300 Wabash Ave, Baltimore Md 21215

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-i show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. TERMINAL ESOPHAGEAL CARCINOMA — 3months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequenca of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [✓] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [✓] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

28. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [✓] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier *(Check only one)*: 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Deborah I Pierce

29c. License number: H45931

29d. Date signed *(Month, Day, Year)*: August 12, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Deborah I Pierce 7220 Park Heights Ave 21208 Baltimore MD

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 18 1999

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

McKay, James

A45

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25956

Henry Miller

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HENRY MILLER
2. Date of Death (Month, Day, Year): August 14 1999
3. Time of Death: 1400
4a. Facility Name (If not institution, give street and number): Sinai Hospital of Baltimore
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 220-07-3959
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MAY 9 1909
9. Birthplace (State or Foreign Country): MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 3646 FOREST HILL ROAD
10f. Zip Code: 21207
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forcas? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexicen, Puerto Ricen, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - Americen Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ARTIST
16b. Kind of Business/Industry: PAINTING
17. Father's Name (First, Middle, Last): ISRAEL MILLER
18. Mother's Name (First, Middle, Meiden Sumame): BERTHA LEVIN
19a. Informant's Name/Relationship (Type, Print): EVA MILLER/WIFE
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 3646 FOREST HILL RD. BALTIMORE, MD. 21207
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): BETH EL MEMORIAL PARK
Date: 8/16/99
20c. Location - City or Town, Stete: RANDALLSTOWN, MD.
21. Signature of Funeral Sarvice Licensee: Robert M. [illegible]
22. Name and Address of Facility: SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel diseasa or condition resulting in death): e. congestive heart failure

Due to (or es a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in death) Lest

b. cardiomyopathy

Due to (or as e consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings available prior to completion of causa of death? 1 [ ] Yes 2 [ ] No

25. Was cese referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Phyelcian:** To the best of my knowledge, death occurred et the time, date and piece, and due to the cause(s) and menner as steted. 2 [ ] **Medical Exeminer:** On the basis of exemination and/or Investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: RES 000
29d. Date signed (Month, Day, Year): August 14, 1999

30. Name end eddress of person who completed ceuse of death (Item 23e) (Type, Print): Sean McCaer DO 2401 West Belvedere Ave. Baltimore M.D. 21215

State Registrar

31. Dete filed (Month, Day, Year): AUG 18 1999
32. Registrar's Signature: [signature]

To the Hospital or Attending Physician: The law requires thet tha death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificata has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for usa as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 16 Rev 6/95

AH 1241

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25957

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Maurice Michelet

2. Date of Death (Month, Dey, Yeer): August 14 1999

3. Time of Death: 10:15 A.M.

4a. Facility Name (If not institution, give street and number): Church Home Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: n/a

Funeral Director

5. Social Security Number: 435 30 8188

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 71 Yrs.

If Under 1 Yeer: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Day, Year): April 18,1928

9. Birthplece (State or Foreign Country): Louisiana

Usual Residence of Decedent

10a. State: Maryland

10b. County: n/a

10c. City, Town or Location: Baltimore

10d. Inside City Limits: ☒Yes 2☐ No

10e. Street end Number: 2021 Spark Ct.

10f. Zip Code: 21231

10g. Citizen ot Whet Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondary (0-12): 5

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Chef

16b. Kind of Business/Industry: Restaurant

17. Father's Name (First, Middle, Last): (Unknown) Michelet

18. Mother's Name (First, Middle, Maiden Surname): (Unknown)

19a. Interment's Name/Relationship (Type, Print): Hazel A. Kent / Companion

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2021 Spark Ct., Baltimore, MD 21231

20a. Method of Disposition: 1☐ Buriel 2☒ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)

20b. Plece of Disposition (Name of cemetery, crematory or other place): Green Mount Crematory

Dete: 8/18/99

20c. Location - City or Town, Stete: Baltimore, MD

21. Signeture of Funeral Service Licensee: Stephen D Lohrmann

22. Name end Address of Fecility: CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr., Baltimore, MD 21286

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heert failure. List only one ceuse on each line.

Approximete Intervel Between Onset end Deeth

Immediete Ceuse (Final diseese or condition resulting in death)

e. Metastatic Anal Cancer — Yeers

Due to (or es a consequence ot):

b. Sepsis

Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in deeth) Last

Due to (or es e consequence ot):

c. Dehydration

Due to (or es e consequence ot):

d.

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Part I.

23b. Did tobecco uee contribute to the cauee of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Plece ot Deeth (Check only one) Hospitel: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner ot Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28a. Dete ot Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At home, tarm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physicien**: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner**: On the besis of exemination end/or investigation, in my opinion, deeth occurred et the time, date end plece, and due to the ceuse(s) end menner stated.

29b. Signeture end title of certifier

29c. License number: D40525

29d. Dete signed (Month, Day, Year): August 14, 1999

30. Neme end eddress ot person who completed cause ot death (Item 23e) (Type, Print): Rudolf Titeuju, M.D. Church Hospital

State Registrar

31. Dete filed (Month, Day, Year): AUG 18 1999

32. Registrer's Signeture: Penny B. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

NAME KNOWN TO PHYSICIAN

permit. PLEASE PRINT OR TYPE

Department of Health and Mental Hygiene

Important: If item 27 is marked other than "natural", or items 23a or 25e-f show any injury or other traumatic event, the Medical Examiner must be notified as soon as possible.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. 99 25958

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): George S. Mallory
2. Date of Death (Month, Day, Year): August 15, 1999
3. Time of Death: 2260
4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER
4b. City, Town, or Location of Death: SALISBURY
4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 220-56-9806
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 44 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 21, 1955
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Worcester
10c. City, Town or Location: Ocean City
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 723C 94th Street
10f. Zip Code: 21842
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Black, White, etc. Specify: White

15. Decadent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Contractor
16b. Kind of Business/Industry: Heating & Air Cond.

17. Father's Neme (First, Middle, Last): Stephen D. Mallory
18. Mother's Name (First, Middle, Meiden Surname): June Verna Reier

19a. Informent's Name/Relationship (Type, Print): Pamela K. Mallory / Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 723 C. 94th Street, Ocean City, Maryland 21842

20e. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, crematory or other piece): Metro Crematory, Inc.
Dete: Aug. 19 1999
20c. Location - City or Town, State: Catonsville, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name end Address of Facility: Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, MD 21061

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

		Approximete Interval Between Onset and Death
Immediate Ceuse (Final disease or condition resulting in deeth) e.	Lymphomatous Meningitis	10 days
Due to (or as e consequenca of): b.	Malignant Lymphoma	4 months
Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in deeth) Last — Due to (or es a consequence of): c.		
d.		

Part II. **Other significant conditiona** contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobacco use contribute to the cauae of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings evallable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end place, end due to the ceuse(s) end menner as steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, end due to the cause(s) and menner stated.
29b. Signature end title of certifier: [signature] M.D.
29c. License number: 030690
29d. Date signed (Month, Day, Year): Aug. 16, 1999
30. Name end address of person who completed cause of death (Item 23a) (Type, Print): James E. Martin, M.D., 145 E. Carroll St., Salisbury, MD 21801

State Registrar

31. Date filed (Month, Day, Year): AUG 18 1999
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use es the burial-transit permit. Peges 1 end 2 should be filed within 72 hours after death with the Marylend Department of Health end Mental Hygiene.
Important: If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

GEORGE MALLORY 220-56-9806

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25959

Certificate of Death

Reg. No.

AMENDED ITEM #20c PER FH G774 8/18/99 AH

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Stella S. Nyann

2. Date of Death Month Day Year: Aug. 3, 1999

3. Time of Death: 8:05

4a. Facility Name (If not institution, give street and number): 13903 Castle Blvd #12

4b. City, Town, or Location of Death: Silver Springs, MD.

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 212-11-8365

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 71 Yrs. | If Under 1 Yeer: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov.19,1927

9. Birthplace (State or Foreign Country): Cape Coast Ghana

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Springs

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 13903 Castle Blvd. #12

10f. Zip Code: 20904

10g. Citizen of Whet Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Black, White, etc. Specify:

15. Decadent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12th. | College (1-4or 5+):

16a. Decadent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Nurse

16b. Kind of Business/Industry: Private

17. Fether's Neme (First, Middle, Last): William Benoni

18. Mother's Name (First, Middle, Meiden Sumeme): Kate Smith

19a. Informant's Neme/Reletionship (Type, Print): Effie Blankson-Wood Daughter

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 13717 Ivywood Lane Silver Spring,MD 20904

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, crematory or other piece): Gate of Heaven

Date: Aug.20 1999 ~~1994~~

20c. Location - City or Town, Stete: Silver Spring,MD.

21. Signeture of Funeral Service Licensee: John W. Latney Jr. CC0348

22. Name end Address of Facility: Latney's Funeral Home,3831 Georgia Ave. NW,Washington,DC 20011

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediete Ceuse (Finat disease or condition resulting in deeth)

e. METASTATIC RENAL CELL CANCER — 4 YEARS

Due to (or es e consequenca of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in deeth) Last

b. Due to (or as a consequenca of):

c. Due to (or as e consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings eveileble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Neturat 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Phyaician:** To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end placa, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: Dr. Sotos

29c. License number: D43083

29d. Date signed (Month, Day, Year): August 17, 1999

30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print): Dr. Sotos 9707 MEDICAL CENTER DRIVE SUITE 320 ROCKVILLE, MD.

State Registrar

31. Date filed (Month, Day, Year): AUG 18 1999

32. Registrer's Signature: Penny B. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

MJ CATE

AH 10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25960

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jean Elaine Johnson Ott
2. Date of Death (Month, Day, Year): August 16 1999
3. Time of Death: 7:35 A.M.
4a. Facility Name (If not institution, give street and number): 12202 Raritan Lane
4b. City, Town, or Location of Death: Bowie
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 515 34 0466
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 61 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 12, 1938
9. Birthplace (State or Foreign Country): Kansas

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Bowie
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 12304 Rockledge Drive
10f. Zip Code: 20715
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - American Indien, Black, Whita, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Engineer
16b. Kind of Business/Industry: Aerospace

17. Father's Name (First, Middle, Last): Harold Johnson
18. Mother's Neme (First, Middle, Maiden Surname): Geneva Bergsten

19a. Informant's Name/Relationship (Type, Print): Lori S. Glaze Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12202 Raritan Lane Bowie Maryland 20715

20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): The Huntt Crematory | Date: August 17, 1999
20c. Location - City or Town, State: Waldorf Maryland

21. Signature of Funeral Service Licensee: Michael L. Bigler
22. Neme end Address of Facility: Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. NON-Hodgkins Lymphoma — 2 years
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medicat examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) Daughter's Home

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: D2640
29d. Date signed (Month, Day, Year): 8-16-99
30. Name and address of person who completed cauth of death (Item 29a) (Type, Print): David Siegel, M.D. 3231 Superior Lane A-6 Bowie Md 20715

State Registrar

31. Date filed (Month, Day, Year): AUG 18 1999
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

A410

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25961

Peterkin, Isabella

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Isabella PeterKiN

2. Dete of Deeth — Month: August — Dey: 15 — Yaar: 1999

3. Time of Death: 3:52 pm

4e. Feclity Nama *(If not institution, give street end number)*: Sinai Hospital of Baltimore

4b. City, Town, or Location of Deeth: Baltimore City

4c. County of Death: N/A

Funeral Director

5. Sociel Security Number: 216-28-6239

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. lest birthdey)*: 73 Yrs. — If Under 1 Yaar: Months / Deys — If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Dey, Year)*: OCT 10, 1925

9. Birthplace *(State or Foraign Country)*: S.C

Usuel Residence of Decedent

10a. Stete: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 2107 Crimea Rd Apt B8

10f. Zip Code: 21207

10g. Citizan of Whet Country?: USA

11. Maritel Status: 1☐ Nevar Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yas 2☒ No — If Yes, Give Yeer or Dates:

13. Wes Dacedant of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 1☐ Yes 2☒ No *Specify:*

14. Rece - Americen Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondery (0-12): 8 — College (1-4or 5+): N/A

16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Computer Flooring

16b. Kind of Business/Industry: DON Floor System

17. Father's Neme *(First, Middle, Last)*: Walter Munford

18. Mother's Name *(First, Middle, Meiden Surneme)*: Elizabeth Boston

19a. Informant's Name/Relationship *(Type, Print)*: JAMES PeteSKin JrlSON

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 16-01 Pheasant Hollow Rd Plainsboro NJ 08536

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Name of cemetery, cremetory or other place)*: King Memorial Park

Dete: 8-20-99

20c. Location - City or Town, Stete: Randallstown MD

21. Signature of Funerel Service Licensee: John B. Jakmen Jr.

22. Name end Address of Facility: March Funeral Home West Inc 4300 WAbash Ave Baltimore md 21215

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part I. Enter the disease, or complicetions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

Approximate Interval Between Onsat and Deeth

Immediete Cause (Final diseesa or condition resulting in death): e. Sepsis with secondary cardiovascular collapse

Due to (or es e consequence of):

Sequentielly list conditions, if eny, leeding to immediete ceuse. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in deeth) Lest:

b. Due to (or es e consequence of):

c. Due to (or es e consequence of):

d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Wes an autopsy performed? 1☐ Yas 2☒ No

24b. Were eutopsy findings available prior to complation of causa of death? 1☐ Yas 2☐ No

25. Wes cese referred to medicel examiner? 1☐ Yes 2☒ No

26. Piece of Deeth *(Check only one)*: Hospitel: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end piece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of exemination end/or investigetion, in my opinion, deeth occurred et the time, date end piece, end due to the ceuse(s) end manner stated.

29b. Signeture end title of certifier: Arthur Li, MD

29c. License number: RES-000

29d. Dete signed *(Month, Day, Year)*: August 15, 1999

30. Name end address of person who completed ceuse of deeth (Item 23e) (Type, Print): Arthur Li, MD, Sinai Hospital of Baltimore

State Registrar

31. Date filed *(Month, Dey, Year)*: AUG 18 1999

32. Registrer's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

AH4

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25962

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Thelma O. Petree
2. Date of Death: Month August Day 17 Year 1999
3. Time of Death: 3:30 P.m.
4a. Facility Name (If not institution, give street and number): North Arundel Hospital
4b. City, Town, or Location of Death: Glen Burnie
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 411.20.1566
6. Sex: 1☐ M 2☒ F XX
7. Age (In yrs. last birthday): 81 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 8/15/1918
9. Birthplace (State or Foreign Country): TN

Usual Residence of Decedent

10a. State: MD
10b. County: CALVERT
10c. City, Town or Location: CHESAPEAKE BEACH
10d. Inside City Limits: 1☐ Yes 2☒ No XX
10e. Street and Number: 3736 13th Street
10f. Zip Code: 20732
10g. Citizen of What Country: USA

11. Marital Status: 1☒ Never Married XX 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No XX If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 1☐ Yes 2☒ No XX Specify:
14. Race - Americen Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: Printing Co.

17. Fether's Name (First, Middle, Last): Othow Petree
18. Mother's Name (First, Middle, Meiden Sumame): Stacy Oskey

19a. Informant's Name/Relationship (Type, Print): Barbara J. Neely - Niece
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 3736 13th St., Chesapeake Bch, MD 20732

20a. Method of Disposition: 1☒ Burial XX 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other piece): Gardens of Faith
Date: 8/20
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Kelly Gregory Fink
22. Name end Address of Facility: FINK FUNERAL HOME, PA
426 Crain Hwy., sw, Glen Burnie, MD 21061

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on eech line. — Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death): e. CONGESTIVE HEART FAILURE
Due to (or as a consequence of):
Sequentielly list conditions, if any, leeding to Immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Last:
b. Due to (or es a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was cese referred to medicel examiner? 1☐ Yes 2☑ No
26. Piace of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how Injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date and place, end due to the ceuse(s) end menner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated.
29b. Signeture and title of certifier: MD
29c. License number: D43977
29d. Date signed (Month, Dey, Year): August 17 1999

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Angelica Chiarenzi. 301 Hospital Drive, Glen Burnie MD 21061.

State Registrar

31. Date filed (Month, Dey, Year): AUG 18 1999
32. Registrar's Signature: Bruce B. Sparks

DHMH 16 Rev 6/95

THELMA PETREE

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25963

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Milton J. Phillips
2. Date of Death: Month August, Day 14, Year 1999
3. Time of Death: 4:55 AM
4a. Facility Name *(If not institution, give street and number)*: Franklin Square Hospital Center
4b. City, Town, or Location of Death: Rosedale
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 213-07-1371
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 83 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Jan 29 1916
9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Essex
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 630 Eastern Ave
10f. Zip Code: 21221
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Rate-Setter
16b. Kind of Business/Industry: Steel

17. Father's Name *(First, Middle, Last)*: Benjamin Posluszny
18. Mother's Name *(First, Middle, Maiden Surname)*: Eleanor Krawcyk

19a. Informant's Name/Relationship *(Type, Print)*: Grace Phillips /wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 630 Eastern Ave Baltimore, MD 21221

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Oak Lawn Cemetery
Date: Aug 17 1999
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: ▶ Anthony C Connelly
22. Name and Address of Facility: Connelly Funeral Home of Dundalk 7110 Sollers Point Rd 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	CONGESTIVE CARDIOMYOPATHY	3 WEEKS
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b.	CORONARY ARTERY DISEASE	17 YEARS
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: ACUTE RENAL FAILURE, PERIPHERAL VASCULAR DISEASE, HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ D.O.
29c. License number: H35593
29d. Date signed *(Month, Day, Year)*: AUG.17,1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. JOHN J. LOH, 1124 MACE AVE., BALTIMORE, MD. 21221

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 18 1999
32. Registrar's Signature: ▶ Penny G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

MJ CATE

A420

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEM #1 PER MD G774 8/20/99 AH

Certificate of Death

Reg. No. 99 25964

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James ~~Robinson~~ ROBINSON Ralph II

2. Date of Death (Month, Day, Year): Aug 13, 1999

3. Time of Death: 7:45 AM

4a. Facility Name (If not institution, give street and number): 64 Olmstead Green

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-30-4133

6. Sex: 1☒M 2☐F

7. Age (In yrs. last birthday): 66 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov 8, 1932

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 64 Olmstead Green

10f. Zip Code: 21210

10g. Citizen of What Country? USA

11. Meritel Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 1☐Yes 2☒No Specify:

14. Rece - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Physician

16b. Kind of Business/Industry: Private Medical Practice

17. Father'a Neme (First, Middle, Last): Bernard Ralph

18. Mothar's Nama (First, Middle, Maiden Sumama): Elizabeth Green

19a. Informent's Name/Retationship (Type, Print): Joan Ralph / Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 64 Olmstead Green Balt Md 21210

20a. Method of Disposition: 1☒Burial 2☐Cremetion 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Nama of cemetery, crematory or other place): Arbutus Memorial Park | Date: 8-20-99

20c. Location - City or Town, State: Arbutus

21. Signature of Funeral Service Licensee: ▶ Gladys Warner

22. Neme and Address of Facility: March Funeral Home West Inc 4350 Wabash Avenue Balt Md 21215

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not entar the mode of dying, such es cardiac or respiretory arrest, shock, or heert failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. ACUTE MYOCARDIAL INFARCTION — 1 HOUR

Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants rasulting in death) Last:

b. ARTERIOSCLEROTIC HEART DISEASE — 10 YEARS

Dua to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: HYPERTENSIVE CARDIOVASCULAR DISEASE

23b. Did tobacco use contributs to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy tindings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case raferred to medicel exeminar? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicida 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☒Certifying Physician: To tha best of my knowledge, death occurred at the tima, date and place, and dua to the cause(s) and mannar as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Donald W. Stewart, M.D. (Attending M.D.)

29c. License number: D10790

29d. Date signed (Month, Day, Year): 8/13/99

30. Name and address of person who completed cause of death (Item 29a) (Type, Print): DONALD W. STEWART, M.D. 2300 GARRISON BLVD. BALTO., MD. 21216

State Registrar

31. Dete filed (Month, Day, Year): AUG 18 1999

32. Registrar's Signatura: Regina B. Sparks

DHMH 16 Rev 6/95

KMS

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25965

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Bossie Wilbur Ryles

2. Date of Death: Month 08 Day 16 Year 99

3. Time of Death: 0645 AM

4a. Facility Name (If not institution, give street and number): Deaton Nursing Home

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: NA

Funeral Director

5. Social Security Number: 226-34-7895

6. Sex: XX M 2☐ F

7. Age (In yrs. last birthday): 68 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 01 05 31

9. Birthplace (State or Foreign Country): V.A.

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 X Yes 2☐ No

10e. Street and Number: 4804 Briarclift Road

10f. Zip Code: 21229

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married XX Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2 X No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 6th grade

College (1-4or 5+): na

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired): Steel Worker

16b. Kind of Business/Industry: Bethlehem Steel

17. Father's Name (First, Middle, Last): George Edward

18. Mother's Name (First, Middle, Maiden Surname): Helen Epps

19a. Informant's Name/Relationship (Type, Print): Sirlilar Stokes-Ryles-Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4804 Briarclift Road, Baltimore Md 21229

20a. Method of Disposition: 1 X Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Garrison Forest Vet

Date: 8/19/99

20c. Location - City or Town, State: Owings Mills, Md

21. Signature of Funarel Service Licensee: Shannon Stokes

22. Name and Address of Facility: March F/H West 4300 Wabash Ave, Baltimore Md 21215

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximata Interval Between Onset and Deeth
Immediata Cause (Final disease or condition resulting in death) a.	acute myocardial infarction	15 minas
Dua to (or es e consequence of): b.	Atherosclerotic heart disease	10yrs
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last — Dua to (or es a consequence of): c.	Chronic renal failure	4 yrs
Due to (or as a consequence of): d.	Diabetes mellitus	10yrs

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause given in Part I.

Hx of fall e subdural hematoma. Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Ware autopsy findings available prior to completion of cause of daath? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☑ Yes 2☐ No

26. Piece of Death (Chack only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Othar: 4☑ Nursing Homa 5☐ Residence 6☐ Other (Specify)

27. Mannar of Death: 1☐ Natural 2☑ Accident 3☐ Suicide 4☐ Homicide 5☐ Panding investigation 6☐ Could not be datarmined

28a. Data of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Phyalcian:** To tha best of my knowledge, death occurred et the time, date and placa, and due to the cause(s) and mannar as statad. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, In my opinion, death occurred et the time, date end place, and dua to the cause(s) and manner stated.

29b. Signature and title of certifier: K. NEGAL MD

29c. License number: D30494

29d. Dete signed (Month, Day, Year): 8/16/99

30. Name and address of person who completed cause of daath (Item 23a) (Type, Print): DMC. 611 South Charles St Baltimore MD 21230

State Registrar

31. Date filed (Month, Day, Year): AUG 18 1999

32. Registrar's Signature: Penny B. Hoskins

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020 Bossie Ryles

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Ryles, Bossie

AH10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND#17 PER F.H. G774 8-18-99 J.A.

Certificate of Death

Reg. No. 99 25966

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day	Year	3. Time of Death
JENNIE	SMITH	August	13	1999	11:25 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SINAI HOSPITAL	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
052-28-4362	1☐ M 2☒ F	89 Yrs.			DEC. 25, 1909	CO

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	BALTIMORE	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2500 W. BELVEDERE AVENUE #1113	21215	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8		FACTORY WORKER	GARMENT

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
JOEL ZUCKERMAN ~~ZUUCKERMAN~~	SYLVIA GOLDSTEIN

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
ROBERTA KAY / DAUGHTER	7202 ROCKLAND HILLS DRIVE #508 - BALTIMORE, MD 21209

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)	MT. MORIAH CEMETERY	8/15/99	FAIRVIEW, NJ

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Scott M. Gottlieb	SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Bilateral Terminal Basal Pneumonia	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. urosepsis	
	Due to (or as a consequence of):	
	c. atrial fibrillation	
	Due to (or as a consequence of):	
	d. acute renal failure	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Kelly Tan MD	AS240221-HT2982	August 13, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Henry Tan MD, Sinai Hospital of Baltimore, 2401 West Belvedere Ave, Baltimore, MD 21215

State Registrar

31. Date Filed (Month, Day, Year)	32. Registrar's Signature
AUG 18 1999	Penelope B. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Patient known as Jennie Smith

AHB

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25967

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ROSA F. STEINER
2. Date of Death (Month, Day, Year): AUGUST 15, 1999
3. Time of Death: 2:30 PM
4a. Facility Name (If not institution, give street and number): LORIEN NURSING HOME
4b. City, Town, or Location of Death: COLUMBIA
4c. County of Death: HOWARD

Funeral Director

5. Social Security Number: 089-09-0868
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 96 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): DEC. 9, 1902
9. Birthplace (State or Foreign Country): NY

Usual Residence of Decedent

10a. State: MD
10b. County: HOWARD
10c. City, Town or Location: COLUMBIA
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 6334 CEDAR LANE
10f. Zip Code: 21044
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): SANDOR FRIEDMAN
18. Mother's Name (First, Middle, Maiden Surname): BERTA SCHROTTER

19a. Informant's Name/Relationship (Type, Print): BERTA STEINER / DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4233 BLUE BARROW RIDE - ELLICOTT CITY, MD 21042

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MT. ZION CEMETERY
Date: 8/17/99
20c. Location - City or Town, State: MASPETH, NEW YORK

21. Signature of Funeral Service Licensee: Robert Levinson
22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	aspiration pneumonia	4 Months
Due to (or as a consequence of): b.	Wallerian degeneration	4 months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	Stroke	4 months
Due to (or as a consequence of): d.		

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: atrial fibrillation

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Richard Lobenthal MD
29c. License number: D31575
29d. Date signed (Month, Day, Year): August 16, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): KOLODNER ET Z 9501 Old Annapolis Rd Ellicott City MD 21042

State Registrar

31. Date filed (Month, Day, Year): AUG 18 1999
32. Registrar's Signature: B. Spates

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

AHS

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25968

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Rosalie Stoyenko
2. Date of Death — Month: 8 Day: 12 Year: 99
3. Time of Death: 16:19
4a. Facility Name (If not institution, give street and number): University of Maryland Medical Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-32-6554
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 66 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): SEPT. 10, 1932
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: RANDALLSTOWN
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 8824 ALLENSWOOD ROAD
10f. Zip Code: 21133
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CLERK
16b. Kind of Business/Industry: U.S. POSTAL SERVICE

17. Father's Name (First, Middle, Last): PHILLIP BERMAN
18. Mother's Name (First, Middle, Maiden Surname): FANNYE SEREBOFF

19a. Informant's Name/Relationship (Type, Print): ESTHER SHAPIRO / DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6832 HAYLEY RIDGE WAY #E - BALTIMORE, MD 21209

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): BETH ISAAC ADATH ISRAEL
Date: 8/15/99
20c. Location - City or Town, State: DUNDALK, MD

21. Signature of Funeral Service Licensee: Robert Levinson
22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Hepatic Failure	1 month
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Hepatitis	1 month
	Due to (or as a consequence of):	
	c. Chronic Renal Failure	1 year
	Due to (or as a consequence of):	
	d. Pancytopenia	1 month

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Gastrointestinal Hemorrhage

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 8☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: William C. Chin, M.D.
29c. License number: 046147
29d. Date signed (Month, Day, Year): 8/12/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William C. Chin, M.D. 22 South Greene Street, Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year): AUG 18 1999
32. Registrar's Signature: Barbara G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

AH6

99-4707-031
CJ
Mark Joseph
Savage

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25969

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARK JOSEPH SAVAGE
2. Date of Death: Month August, Day 14, Year 1999
3. Time of Death: 07:58 AM.
4e. Facility Name (If not institution, give street and number): Suburban Hospital
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 316-90-3702
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 22 Yrs. — If Under 1 Year: Months, Days; If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): JUNE 20, 1977
9. Birthplace (State or Foreign Country): ALABAMA

Usual Residence of Decedent

10a. State: ALABAMA
10b. County: JEFFERSON
10c. City, Town or Location: BIRMINGHAM
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 3706 BROOKWOOD RD.
10f. Zip Code: 35223
10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): STUDENT
16b. Kind of Business/Industry: EDUCATION

17. Father's Name (First, Middle, Last): FRANCIS XAVIER SAVAGE
18. Mother's Name (First, Middle, Maiden Surname): GERIANNE AGNEW SAVAGE

19a. Informant's Name/Relationship (Type, Print): FRANCIS SAVAGE/FATHER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3706 BROOKWOOD RD., BIRMINGHAM, ALABAMA 35223

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ELMWOOD CEMETERY
Date: 8/20/99
20c. Location - City or Town, State: BIRMINGHAM, AL.

21. Signature of Funeral Service Licensee: [signature] 2521
22. Name and Address of Facility: CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVE., BALTIMORE, MD. 21224

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Multiple injuries
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year): 8-14-99
28b. Time of Injury: 0418 M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: Driver of car in collision with van
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Highway - Beltway
28f. Location (Street and Number or Rural Route Number, City or Town, State): Washington Beltway East of Connecticut Ave
29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] A.M. DIXON
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): August 15, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): AUG 18 1999
32. Registrar's Signature: [signature] G. Sparks

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.
To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25970

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ARTHUR G. SIWINSKI, M.D.

2. Date of Death Month Day Year: August 15, 1999

3. Time of Death: 5:45 PM

4a. Facility Name *(If not institution, give street and number)*: 1538 Manchester Rd.

4b. City, Town, or Location of Death: Westminster

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 220-34-6639

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 93 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec. 7, 1905

9. Birthplace *(State or Foreign Country)*: Md.

Usual Residence of Decedent

10a. State: Md.

10b. County: Carroll

10c. City, Town or Location: Westminster

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 1538 Manchester Rd.

10f. Zip Code: 21157

10g. Citizen of What Country?: USA

11. Meritel Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: WW-II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12 | College (1-4or 5+): 5+

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Radiologist

16b. Kind of Business/Industry: Medical

17. Father's Name *(First, Middle, Last)*: George W. Siwinski

18. Mother's Name *(First, Middle, Maiden Surname)*: Jennie Dulski

19a. Informent's Neme/Relationship *(Type, Print)*: Mrs. Martha Siwinski/wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1538 Manchester Rd. Westminster, Md. 21157

20a. Method of Disposition: 1 ☐ Buriel 2 ☒ Cremetion 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other piece)*: Hilltop Service Corp. Date: 8/20/99

20c. Location - City or Town, State: Towson, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part1. Enter the diseesa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heert tailure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)
a. Congestive Heart failure — 1 year

Due to (or as a consequence of):
b. Aortic valve disease — 5 years

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury thet initiated events rasulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Coronary artery disease

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Wes an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other *(Specify)*

27. Menner of Death: 1 ☒ Naturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigetion 6 ☐ Could not be determined

28a. Dete of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated. 2 ☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end piece, and due to the cause(s) and menner stated.

29b. Signature and title of certifier

29c. License number: A36796

29d. Date signed *(Month, Day, Year)*: 8·17·99

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Charles C Cummings 8600 Liberty Rd Randallstown MD 21133

State Registrar

31. Dete filed *(Month, Day, Year)*: AUG 18 1999

32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25971

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John Joseph Sullivan Jr.
2. Date of Death (Month, Day, Year): Aug 15 1999
3. Time of Death: 0048
4a. Facility Name (If not institution, give street and number): 204 Hollywood Court
4b. City, Town, or Location of Death: Glen Burnie
4c. County of Death: AA.

Funeral Director

5. Social Security Number: 092-20-2308
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 71 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): APRIL 24, 1928
9. Birthplace (State or Foreign Country): NEW YORK

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: GLEN BURNIE
10d. Inside City Limits: 1 [ ] Yes [X] No
10e. Street and Number: 204 HOLLYWOOD COURT
10f. Zip Code: 21060
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No. If Yes, Give Year or Dates: 1946-1968
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): FINANCE ANALYST
16b. Kind of Business/Industry: U.S. GOVERNMENT

17. Father's Name (First, Middle, Last): JOHN J. SULLIVAN
18. Mother's Name (First, Middle, Maiden Surname): MARY E. HEALY

19a. Informant's Name/Relationship (Type, Print): MRS. ELIZABETH SULLIVAN (WIFE)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 204 HOLLYWOOD COURT, GLEN BURNIE, MARYLAND 21061

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MARYLAND VETERANS CEMETERY
Date: 8/18/99
20c. Location - City or Town, State: CROWNSVILLE, MD.

21. Signature of Funeral Service Licensee: Paul D. Hagan
22. Name and Address of Facility: SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Arteriosclerotic Heart Disease UNK.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: William P. Jones, Deputy MD
29c. License number: D 06054
29d. Date signed (Month, Day, Year): 8/15/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William P. Jones, MD 695 America 21035

State Registrar

31. Date filed (Month, Day, Year): AUG 18 1999
32. Registrar's Signature: James P. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25972

Certificate of Death Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: CATHERINE SANTAVICCA
2. Date of Death Month: 8 Day: 17 Year: 99
3. Time of Death: 4 AM
4a. Facility Name *(If not institution, give street and number)*: 9816 Bridle Brook Drive
4b. City, Town, or Location of Death: Owings Mills
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 185-34-5112
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 56 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: March 8, 1943
9. Birthplace *(State or Foreign Country)*: PA

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Owings Mills
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 9816 Bridle Brook Drive
10f. Zip Code: 21117
10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Spacify only highest grada completad)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+)
16a. Decedent's Usual Occupation *(Give kind of work dona during most of working life. DO NOT usa ratired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: George Sekerchak
18. Mother's Name *(First, Middle, Maidan Sumema)*: Catherine Busha

19a. Informant's Name/Relationship *(Type, Print)*: Adam Santavicca Husband
19b. Mailing Address *(Street end Number or Rural Routa Number, City or Town, State, Zip Code)*: 9816 Bridle Brook Drive, Owings Mills, MD 21117

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Carroll Cremation
Date: 8/17/99
20c. Location - City or Town, State: Hampstead, MD

21. Signature of Funeral Service Licensee: D. L. Shaw
22. Name and Address of Facility: 11824 Reisterstown Rd. Eline Funeral Home Reisterstown, MD 21136

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heert feilure. List only ona ceuse on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finel disease or condition resulting in death)	a. BREAST CANCER	6 YRS
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
Due to (or es e consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco uss contribute to the causs of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was cese referred to medicei examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Routa Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at tha time, date and place, and due to the ceuse(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and piace, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD
29c. License number: D35606
29d. Date signed *(Month, Day, Year)*: 8/17/99

30. Neme and eddress of person who completed ceuse of death (Item 23e) (Type, Print): Samuel Zysler M.D. 21 Crossroads Drive #415 owings Mills MD 21117

State Registrar

31. Date filed *(Month, Day, Yaar)*: AUG 18 1999
32. Registrar's Signature: Lenora B. Parker

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

A-20

99 25973

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Librada Serrano			2. DATE OF DEATH (Month, Day, Year): August 14 1999	3. TIME OF DEATH: 2:00 A.M. M
4. SOCIAL SECURITY NUMBER: 215 31 3915	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 98 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Oct. 1, 1900	8. BIRTHPLACE (State or Foreign Country): Panama
9a. FACILITY NAME (If not institution, give street and number): Crofton Convalescent Center		9b. CITY, TOWN OR LOCATION OF DEATH: Crofton		9c. COUNTY OF DEATH: Anne Arundel

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Anne Arundel	10c. CITY, TOWN OR LOCATION: Odenton	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 514 Prince Charles Ave.		10f. ZIP CODE: 21113	10g. CITIZEN OF WHAT COUNTRY? Panama

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) ☒ YES 2 ☐ NO Specify: Panama	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 3; College (1-4 or 5+): 0	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Own Home	
17. FATHER'S NAME (First, Middle, Last): Catalino Flores		18. MOTHER'S NAME (First, Middle, Maiden Surname): Josefina Guardia	
19a. INFORMANT'S NAME (Type/Print): Wendy Rojas Granddaughter	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 514 Prince Charles Ave. Odenton Maryland 21113		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Maryland National Memorial Park	DATE: August 17, 1999	20c. LOCATION — City or Town, State: Laurel Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Michael L. Bigler	22. NAME AND ADDRESS OF FACILITY: Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Congestive Heart Failure	
	DUE TO (OR AS A CONSEQUENCE OF): Coronary artery disease	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF): Hypertension	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	28. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	26a. DATE OF INJURY (Month, Day, Year)	26b. TIME OF INJURY M	26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	26d. DESCRIBE HOW INJURY OCCURED		
	26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D46846	29d. DATE SIGNED (Month, Day, Year) ▶ 8/16/99
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 23) (Type, Print): AON II CHOICE 7575 Ritchie Hwy Glen Burnie MD		
31. DATE FILED (Month, Day, Year): AUG 18 1999	32. REGISTRAR'S SIGNATURE: D. Sparks	

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MD CME

A43

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 25974

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: John Edward Singer, Jr.

2. Date of Death Month / Day / Year: August 15, 1999

3. Time of Death: 7:30am

4a Facility Name *(If not institution, give street and number)*: VAMHCS Fort Howard Division

4b. City, Town, or Location of Death: Fort Howard

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 213288157

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 67 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: September 20, 1931

9. Birthplace *(State or Foreign Country)*: Baltimore, Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Baltimore County

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 115 Leslie Avenue

10f. Zip Code: 21236

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1948-1952

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10; College (1-4or 5+): N/A

18a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Electrician

16b. Kind of Business/Industry: Electrical Industry

17. Father's Name *(First, Middle, Last)*: John Edward Singer, Sr.

18. Mother's Nama *(First, Middle, Maiden Surname)*: Mabel V. Dorey

19a. Informant's Name/Relationship *(Type, Print)*: Jacquelyn M. Singer (Wife)

19b. Malling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 115 Leslie Avenue Baltimore, Md. 21236

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Othar *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Parkwood Cem.

Date: August 18, 1999

20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: ▶ Heather Lassahn Chamecki

22. Name and Address of Facility: Lassahn Funeral Home, Inc. 7401 Belair Road Baltimore, Maryland 21236-4625

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or haart failura. List only ona causa on aach lina.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Small Cell Carcinoma — Unknown

Due to (or as a consequence of):
b. Metastasis to Brain — 2 Months

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Causa (Disease or Injury that Initiated events resulting in deeth) Lest
Due to (or as a consequence of):
c.
Due to (or as e consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Mannar of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Data of Injury *(Month, Day Yeer)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ George E. Wicks III M.D.

29c. License number: D41365

29d. Dete signed *(Month, Day, Year)*: August 15, 1999

30. Nama and address of person who complated causa of daath (Item 23a) (Type, Print): George Wicks, MD 9600 North Point Road, Fort Howard, MD 21052

State Registrar

31. Data filed *(Month, Day, Year)*: AUG 18 1999

32. Registrar's Signature: ▶ Nina G. Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Name: John E. Singer

A467-1

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25975

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Gallie P Thorpe
2. Date of Death: Month August Day 16 Year 1999
3. Time of Death: 12:30
4a. Facility Name (If not institution, give street and number): Johns Hopkins Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: NA

Funeral Director

5. Social Security Number: 245-54-6050
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 62 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 04-09-37
9. Birthplace (State or Foreign Country): NC

Usual Residance of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10a. Street and Number: 920 Bonaparte Avenue
10f. Zip Code: 21218
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yes, Give Year or Detas:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Bleck, White, atc. Specify: Black

15. Decedent's Education (Specify only highast grede completed): Elementery/Secondery (0-12): 12th Grade; College (1-4or 5+): AA Degree
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Para Professional
16b. Kind of Business/Industry: City of Baltimore

17. Father's Neme (First, Middle, Last): Robert H. Baird
18. Mother's Neme (First, Middle, Meiden Surname): Adelle DeShazo

19a. Informent's Name/Relationship (Type, Print): Deborah Thorpe
19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 1116 Walker Avenue Baltimore, Maryland 21239

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Kings Mem. PK. Cem.
Date: 08-21-99
20c. Location - City or Town, Steta: Randallstown, MD

21. Signeture of Funeral Service Licensee: Vanessa Cook
22. Name end Addrass of Feciility: Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter tha moda of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line.

		Approximate Interval Between Onset end Death
Immediate Cause (Final disaase or condition resulting in deeth) a.	Sepsis	24 hours
Due to (or es a consequence of):		
Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Lest b.	Spontaneous bacterial peritonitis	36 days
Due to (or as a consequence of):		
c.	End stage renal disease	4 years
Due to (or es e consequenca of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobecco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, date and placa, end due to the cause(s) and menner steted.
29b. Signature and Title of certifier: Patty Chi MD
29c. Licanse number: RES-000
29d. Dete signed (Month, Day, Year): 8/16/99

30. Neme end address of person who completed cause of death (Item 23e) (Type, Print): Patty Chi MD Johns Hopkins Hospital 600 N. Wolfe Street Baktimore, MD

State Registrar

31. Dete filed (Month, Day, Year): AUG 18 1999
32. Registrer's Signature: Bonnie G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25976

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HERMAN Edward Tinsley
2. Date of Death (Month, Day, Year): August 13 1999
3. Time of Death: 3:00 PM
4a. Facility Name (If not institution, give street and number): 3219 Shannon Drive
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: none

Funeral Director

5. Social Security Number: 219-38-0922
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 57 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 19 1942
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: none
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 3219 Shannon Drive
10f. Zip Code: 21213
10g. Citizen of What Country? USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: African American

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Painter
16b. Kind of Business/Industry: Windemer Company

17. Father's Name (First, Middle, Last): HERMAN Tinsley
18. Mother's Name (First, Middle, Maiden Surname): Anna Hairston

19a. Informant's Name/Relationship (Type, Print): Sofia Hopkins
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3219 Shannon Drive Balto, Md 21213

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt Zion
Date: 8/18/99
20c. Location - City or Town, State: Lansdowne, Maryland

21. Signature of Funeral Service Licensee: Nancy M. Wallace
22. Name and Address of Facility: Nancy M. Wallace Funeral Service, 3405 W. Franklin Street, Baltimore, Maryland 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardiomyopathy
Due to (or as a consequence of):
b. Infection MI
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c. Alcoholism
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Tobacco abuse
Recent Above Knee Amputation
Inanition

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D34146
29d. Data signed (Month, Day, Year): 8/17/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Murray West MD 3301 Belair Rd Bald MD 21213

State Registrar

31. Data filed (Month, Day, Year): AUG 18 1999
32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

MJ GATE

AH3

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25977

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ALBERT TROUT
2. Date of Death Month: AUGUST Day: 15 Year: 1999
3. Time of Death: 6:00 PM
4a. Facility Name *(If not institution, give street and number)*: 1323 Walnut Hill Lane
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 046 28 8227
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 69 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Dec. 13,1929
9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Towson
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1323 Walnut Hill Lane
10f. Zip Code: 21204
10g. Citizen of Whet Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, atc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Raca - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working life. DO NOT usa ratired)*: Engineer
16b. Kind of Business/Industry: Industrial Handling

17. Fether's Neme *(First, Middle, Last)*: hugh Henry Trout
18. Mother's Name *(First, Middle, Maidan Surnama)*: Alice Green

19a. Informant's Name/Relationship *(Type, Print)*: Jean Trout / Wife
19b. Mailing Address *(Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 1323 Walnut Hill Lane, Baltimore, MD 21204

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Placa of Disposition *(Nama of camatary, cramatory or othar placa)*: Green Mount Crematory — Data: 8/17/99
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Stephen D Lohrmann
22. Nama and Address of Facility: CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr., Baltimore, MD 21286

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that causad the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Ceuse (Final diseese or condition resulting in death): a. SARCOMA — 1 YR

Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Dua to (or as a consaquance of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the causa of death? 1 [ ] Yss 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how Injury occurred
28e. Placa of Injury - At home, farm, street, factory, offica building, etc. *(Spacify)*
28f. Location *(Streat and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examinar:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: GIL
29c. License number: D27736
29d. Date signed *(Month, Day, Year)*: 8/16/99
30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): GARY COHEN, MD 6716 N. CHARLES ST. BALTO MD 21204

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 18 1999
32. Registrar's Signature: Bonnie B. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

99-4657-025
CJ
Paul Phillip
Taylor

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #23 PART I, 27, 28 A-F PER MEO G775 9-23-99 WR.

Certificate of Death

Reg. No. 25978

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
PAUL TAYLOR	August	11	1999	11:45 AM.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
4604-B Annhurst	Belcamp	Harford

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-06-9578	1 M 2 F	28 Yrs.			5-6-1971	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	HARFORD	BELCAMP	1 Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4604-B ANNHURST COURT	21017	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1 Yes 2 No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	4	COMPUTER PROGRAMMER	SOFTWEAR DEVELOPMENT CO.

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
MATTHEW M. TAYLOR	DELORES WEEKS

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MATTHEW TAYLOR FATHER	2531 SANDY RUN COURT, ANNAPOLIS, MARYLAND 21401

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	CHESAPEAKE CREMATION CENTER	8-17-1999	CHESTER, MARYLAND

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
	SINGLETON FUNERAL HOME, P.A. 1 SECOND AVE. S.W. GLEN BURNIE, MD 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. DIPHENHYDRAMINE INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 No

26. Place of Death (Check only one)
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA
Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death: 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day, Year) Found: 8-11-99

28b. Time of Injury Found: 9:40 A M

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred: UNKNOWN

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): FOUND: RESIDENCE

28f. Location (Street and Number or Rural Route Number, City or Town, State): 4604-B ANNHURST BELCAMP, MARYLAND

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Wayne MacHale	O.C.M.E.	August 12, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Kathryn D. Kolkhorst M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
AUG 18 1999	Barbara G. Spates

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25979

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Thomas Vint

2. Date of Death (Month, Day, Year): AUG 17 99

3. Time of Death: 850A

4a. Facility Name (If not institution, give street and number): Lorian Nursing Home

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

Funeral Director

5. Social Security Number: 217-32-2218

6. Sex: XX M 2☐ F

7. Age (In yrs. last birthday): 62 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 01 22 37

9. Birthplace (State or Foreign Country): D.C.

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Towson

10d. Inside City Limits: 1☐ Yes 2XX No

10e. Street and Number: 35 Acorn circle #301

10f. Zip Code: 21286

10g. Citizen of What Country: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade; College (1-4or 5+): 5+ yrs

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Professor

16b. Kind of Business/Industry: Morgan State Univ.

17. Father's Name (First, Middle, Last): Thomas Vint

18. Mother's Name (First, Middle, Maiden Surname): Mary Waring

19a. Informant's Name/Relationship (Type, Print): Safieh Laaly-Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 35 Acorn Circle #301, Towson Md 21286

20a. Method of Disposition: XX Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): King Memorial Park

Date: 8/19/99

20c. Location - City or Town, State: Randallstown, Md

21. Signature of Funeral Service Licensee: Jeanne A. Thompson

22. Name and Address of Facility: March F/H West 4300 Wabash Ave, Baltimore Md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Central Nervous System Hemorrhage — 9 Months

Due to (or as a consequence of):

b. Hypertension — 5 Years

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Respiratory Failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) end menner stated.

29b. Signature and title of certifier: Sanjay P. Shah, MD

29c. License number: D0052940

29d. Date signed (Month, Day, Year): AUG 17 99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): SANJAY P. SHAH, MD 10905 Hickory Ridge Rd. #210, Columbia, MD 21044

State Registrar

31. Dete filed (Month, Day, Year): AUG 18 1999

32. Registrar's Signature: Anne B. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25980

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FLORA WALKER

2. Date of Death: Month AUG Day 15 Year 1999

3. Time of Death: 5:00 PM

4a. Facility Name (If not institution, give street and number): 3312 SPALDING AVE

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 227-38-6535

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 65 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 3-31-34

9. Birthplace (State or Foreign Country): NORTH CAROLINA

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 3312 SPALDING AVE

10f. Zip Code: 21215

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOUSE WIFE

16b. Kind of Business/Industry: DOMESTIC

17. Father's Name (First, Middle, Last): MILLER STEVENSON

18. Mother's Name (First, Middle, Maiden Surname): ADA MARTIN

19a. Informant's Name/Relationship (Type, Print): VICTORIA SULLIVAN (SISTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3312 SPALDING AVE, BALTO, MD 21215

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): MOUNT ZION

Date: 8-21-99

20c. Location - City or Town, State: ELLICOTT CITY

21. Signature of Funeral Service Licensee:

22. Name And Address of Facility: HOWELL 4600 FUNERAL HOME Liberty Hgts Ave.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. SEPSIS
Due to (or as a consequence of):
b. DIABETES MELLITUS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. CEREBRO VASCULAR ACCIDENT
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: 040343

29d. Date signed (Month, Day, Year): 8/18/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 2209 Kernan Drive Baltimore MD 21207 Donald Shell, M.D.

State Registrar

31. Date filed (Month, Day, Year): AUG 18 1999

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

WRC
99-4733-510
MARY
WHITE

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25981

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY Helen White
2. Date of Death Month: AUGUST Day: 15, Year: 1999
3. Time of Death: 8:41 PM.
4a. Facility Name (If not institution, give street and number): 6310 GREENSPRING AVE. APT. 206
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-18-3394
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 20, 1916
9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 6310 Greenspring Ave Apt 206
10f. Zip Code: 21209
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Bleck, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cook
16b. Kind of Businass/Industry: Spring Groove State Hosp.

17. Father's Nema (First, Middle, Last): Eli Jordan
18. Mother's Name (First, Middle, Maiden Sumeme): Irene Gray

19a. Informent's Neme/Reletionship (Type, Print): Barbara Wright / niece
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1037 Flagtree Lane Pikesville MD 21208

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other piece): Arbutus
Date: 8-19-99
20c. Location - City or Town, State: Arbutus

21. Signeture of Funaral Service Licensee: Shannon S. Akes
22. Name and Address of Facility: March Funeral Home West Inc. 4300 WAbash Ave Baltimore Md 21215

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errast, shock, or heert failure. List only ona cause on each line. — Approximata Intarvel Between Onset and Death

Immediete Causa (Final disease or condition resulting in death)
a. Arteriosclerotic Cardiovascular Disease
Due to (or as a consequance of):
b.
Sequentially list conditions, if any, leading to immediata cause. Entar Underlying Cause (Disease or injury that initieted events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or es a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Diabetes mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performed? INSPECTION 1☐ Yes 2☒ No
24b. Wara autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At homa, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☐ **Certifying Physician**: To tha best of my knowledge, death occurred at the time, date and place, and dua to the cause(s) end menner es stated. 2☒ **Medical Examiner**: On tha basis of examinetion and/or investigation, in my opinion, death occurred at tha tima, data and place, and due to tha cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: O.C.M.E.
29d. Deta signed (Month, Day, Year): AUGUST 16, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ann Dixon M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filed (Month, Day, Year): AUG 18 1999
32. Registrer's Signature: Barbara G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To be completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

A1-10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25982

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HELEN E. WALTEMEYER
2. Date of Death: Month AUG Day 11 Year 1999
3. Time of Death: 12:35 a.m.
4a. Facility Name (If not institution, give street and number): Howard County General Hospital
4b. City, Town, or Location of Death: Columbia
4c. County of Death: Howard

Funeral Director

5. Social Security Number: 217-22-2691
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 93 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): October 5,1905
9. Birthplace (State or Foreign Country): Hungary

Usual Residence of Decedent

10a. State: Maryland
10b. County: Howard
10c. City, Town or Location: West Friendship
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3005 Sobus Drive
10f. Zip Code: 21794
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): housewife
16b. Kind of Business/Industry: home

17. Father's Name (First, Middle, Last): John Halas
18. Mother's Name (First, Middle, Maiden Surname): Ida G. (unk.)

19a. Informant's Name/Relationship (Type, Print): William L. Willie - grandson
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3005 Sobus Drive, West Friendship, Maryland 21794

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Loudon Park Cemetery | Date: 8/14/99
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Ann Y. Zink
22. Name and Address of Facility: Loudon Park Funeral Home, 3620 Wilkens Avenue, Baltimore, MD 21229

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. VENTRICULAR FIBRILLATION — MINUTES

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: HYPERTENSION, ANEMIA, RENAL INSUFFICIENCY

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier: [signature] MD
29c. License number: D38296
29d. Date signed (Month, Day, Year): AUGUST 12, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOSEPH F. GIBBONS, MD 9501 OLD ANNAPOLIS RD, ELLICOTT CITY, MD 21042

State Registrar

31. Date filed (Month, Day, Year): AUG 18 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

A776

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25983

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Betty Wilson

2. Date of Death Month: 8 Day: 14 Year: 99

3. Time of Death: 2:40PM

4e. Facility Name (If not institution, give street and number): Bon Secours Hosp.

4b. City, Town, or Location of Death: Balto

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-28-2644

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 67 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 13, 1932

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2409 Harlem Ave.

10f. Zip Code: 21216

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Afro-American

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher

16b. Kind of Business/Industry: Balto. Public Schools

17. Father's Name (First, Middle, Last): Moses Coleman

18. Mother's Name (First, Middle, Maiden Surname): Georgia Johnson

19a. Informant's Name/Relationship (Type, Print): Mr. Frank Wilson (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2409 Harlem Ave. Balto. Md. 21216

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Garrison Forest

Date: 8/19/99

20c. Location - City or Town, State: Owings Mills, Md.

21. Signature of Funeral Service Licensee: Joseph L. Russ

22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardiopulmonary ARREST

Due to (or as a consequence of):

b. Coronary Artery Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension, Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: F.A. Hamilton, M.D., Medical Staff

29c. License number: D08291

29d. Date signed (Month, Day, Year): August 14, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): F. A. HAMILTON, M.D., Bon Secours Hosp. 2000 W. Baltimore St, Baltimore Md 21223

State Registrar

31. Date filed (Month, Day, Year): AUG 18 1999

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

AH15

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25984

AMENDED ITEM #18 PER FH G774 8/18/99 AH

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CLIFROD WHITE

2. Date of Death: Month AUGUST Day 12, Year 1999

3. Time of Death: 4:30PM

4a. Facility Name (If not Institution, give street and number): Northwest Hospital

4b. City, Town, or Location of Death: N/A

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-16-9225

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 91 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 9, 1908

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Owings Mills

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: P.O. Box 165

10f. Zip Code: 21117

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Barber

16b. Kind of Business/Industry: Hospital

17. Father's Name (First, Middle, Last): George White

18. Mother's Name (First, Middle, Maiden Surname): ~~Lenora Riggs~~ LENORA LEWIS

19a. Informant's Name/Relationship (Type, Print): Mrs. Virginia Scott (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 165 Owings Mills, Md. 21117

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): St. Luke Cemetery

Date: 8/17/99

20c. Location - City or Town, State: Reisterstown, Md.

21. Signature of Funeral Service Licensee: Joseph L. Russ

22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Congestive Heart Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic renal failure

Anemia

DJD

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D44505

29d. Date signed (Month, Day, Year): August 12, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): A.J. IMPERIAL, JR. MD - NW Hc

State Registrar

31. Date filed (Month, Day, Year): AUG 18 1999

32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

A47

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25985

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: John K. Wilhelm

2. Date of Death — Month: August Day: 15 Year: 1999

3. Time of Death: 7:53P

4a. Facility Name *(If not institution, give street and number)*: Baltimore VA Medical Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-30-0792

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 66 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Nov. 13, 1932

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 4400 Newport Avenue

10f. Zip Code: 21211

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1950 - 1954

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Oil Burner Technician

16b. Kind of Business/Industry: Heating

17. Father's Name *(First, Middle, Last)*: John K. Wilhelm, Sr.

18. Mother's Name *(First, Middle, Maiden Sumeme)*: Frances Baker

19a. Informant's Name/Relationship *(Type, Print)*: Mrs. Carolyn J. Wilhelm (wife)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4400 Newport Avenue Baltimore, Maryland 21211

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gardens of Faith Cem. Date: 8/19/99

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Michael E. Canapp

22. Name and Address of Facility: LEONARD J. RUCK, INC. 5305 Harford Road Baltimore, MD 21214

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Pneumonia	4 hours
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Lung Abscess	1 Year
	Due to (or as a consequence of):	
	c. Lung Cancer	2 Years
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Coronary Artery Disease; Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner es stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Harold Pierre, MD

29c. License number: P13404

29d. Date signed *(Month, Day, Year)*: August 15, 1999

30. Name and address of person who completed cause of death (item 23a) (Type, Print): Harold Pierre 22 S. Greene Street, Baltimore, MD 21201

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 18 1999

32. Registrar's Signature: Geneva G. Sparks

DEC 2 0 1999

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

47 5T1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: #26 PER MD G774 8-18-99 WR.

Certificate of Death

Reg. No. 99 25986

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): SIDNEY ROBERT WILLIAMS, SR.

2. Date of Death (Month, Day, Year): August 15, 1999

3. Time of Death: 12:06 AM

4a. Facility Name (If not institution, give street and number): Johns Hopkins Bayview Medical Ctr.

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-24-0845

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 71 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 6, 1927

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Dundalk

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 105 Wise Avenue

10f. Zip Code: 21222

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No. If Yes, Give Year or Dates: 1947

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 Years | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Steel Roller

16b. Kind of Business/Industry: Steel Industry

17. Father's Name (First, Middle, Last): Frederick E. Williams, Jr.

18. Mother's Name (First, Middle, Maiden Surname): Hilda Yammer

19a. Informant's Name/Relationship (Type, Print): Mrs. Helen Williams / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 105 Wise Ave. Dundalk, Maryland 21222

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Oak Lawn Cemetery | Date: 8/19/1999

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Hilton W. Fell

22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 22a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Acute Myocardial infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus.

Congestive Heart failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 8☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M To [illegible] MD Physician

29c. License number: D21859.

29d. Date signed (Month, Day, Year): 8/16/99.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MOHAMMAD TAQIMD 6710 Holabird AVEN BALT MD 21222.

State Registrar

31. Date filed (Month, Day, Year): AUG 18 1999

32. Registrar's Signature: [illegible] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25987

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Ruth Virginia Wroten

2. Dete of Deeth: Month August Day 15, Year 1999

3. Time of Deeth: 8:00 a.m.

4e. Fecility Neme (If not institution, give street end number): Mariner Health and Rehab. of Glen Burnie

4b. City, Town, or Location of Deeth: Glen Burnie

4c. County of Deeth: Anne Arundel

Funeral Director

5. Sociel Security Number: 212.10.5043

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. lest birthday): 82 Yrs. | If Under 1 Yeer: Months / Deys | If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Dey, Yeer): 7/22/1917

9. Birthplece (Steta or Foreign Country): Maryland

Usual Residence of Decedent

10a. Stete: MD

10b. County: Anne Arundel

10c. City, Town or Location: Glen Burnie

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 200 Ferndale Road

10f. Zip Code: 21061

10g. Citizen of Whet Country?: USA

11. Maritel Status: 1☐ Never Merried 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | Collega (1-4or 5+):

16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use ratired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Fether's Name (First, Middle, Last): Jesse Grimm

18. Mother's Neme (First, Middle, Meiden Sumame): Mary E. Grimm

19a. Informent's Neme/Relationship (Type, Print): Rose Anthony - Daughter

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 8236 Bayside Dr., Pasadena, MD 21122

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other piece): Meadowridge Mem. PK.

Deta: 8/18

20c. Location - City or Town, Stete: Elkridge MD

21. Signeture of Funeral Service Licensee: Kelly Gregory Fink

22. Name end Address of Fecility: FINK FUNERAL HOME, PA
426 Crain Hwy., SW, Glen Burnie, MD 21061

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert failure. List only one ceuse on eech line.

Approximete Interval Between Onset and Deeth

Immediate Ceuse (Final disease or condition resulting in deeth)
e. Sepsis. — Two day

Due to (or es e consequance of):
b. Old stroke — Years

Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceusa (Disaase or injury thet initieted evants resulting in deeth) Lest
c. Atherosclerotic cardiovascular disease — Years

Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Ware autopsy findings eveilable prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was cese referred to medical exeminer? 1☐ Yes 2☒ No

26. Plece of Deeth (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residance 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Panding investigation 6☐ Could not be detarmined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Plece of Injury - At home, farm, streat, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete end plece, end due to the ceuse(s) end menner es stetad. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end plece, end due to the cause(s) end mannar stated.

29b. Signature and title of certifier: Attending Physician

29c. License number: D44973

29d. Date signed (Month, Dey, Year): Aug 17th 1999

30. Name end eddress of person who complated causa of deeth (Item 23e) (Type, Print): GURMEET S. SAWHNEY MD.
325 Hospital Drive 202, Glen Burnie, MD 21061

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Dete filed (Month, Day, Year): AUG 18 1999

32. Registrar's Signature: Barbara A. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25988

AKA: MARK L. WINGATE

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mark L. Wingate

2. Data of Death: Month August Day 15, Year 1999

3. Time of Death: 4:25 PM

4a. Facility Name (If not institution, give street and number): VAMC FORT HOWARD DIVISION

4b. City, Town, or Location of Death: Fort Howard

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 218-58-2756

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 48 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): Dec. 4,1950

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Howard

10c. City, Town or Location: Glenelg

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 12924 Folly Quarter Rd.

10f. Zip Code: 21787

10g. Citizen of What Country? United States

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1971-73

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Marine Engineer

16b. Kind of Business/Industry: Research

17. Father's Name (First, Middle, Last): (Unknown)

18. Mother's Name (First, Middle, Maiden Surname): (Unknown)

19a. Informant's Name/Relationship (Type, Print): Paula Niese / Personal Representative

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12924 Folly Quarter Rd., Glenelg, MD 21787

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Green Mount Crematory | Date: 8/17/99

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Stephen D. Lohrmann

22. Name and Address of Facility: CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr., Baltimore, MD 21286

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Chronic Lymphocytic Leukemia	4 Years
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.		
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Cirrhosis, Hepatitis C, Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: George E. Wicks III M.D.

29c. License number: D41365

29d. Date signed (Month, Day, Year): August 15, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): George E. Wicks, MD 9600 North Point Road Fort Howard, MD 21052

State Registrar

31. Date filed (Month, Day, Year): AUG 18 1999

32. Registrar's Signature: B. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completed/filled in by the funeral director, page 2 should be detached for use as the burial-transit

6 of 1

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25989

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Charles William Wagner
2. Date of Death (Month, Day, Year): August 14, 1999
3. Time of Death: 7:03 PM
4a. Facility Name (If not institution, give street and number): Stella Maris
4b. City, Town, or Location of Death: Timonium
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 213-20-8598
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 72 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 9, 1927
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 2423 Southwest Road
10f. Zip Code: 21234
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Electrcal Engineer
16b. Kind of Business/Industry: Government

17. Father's Name (First, Middle, Last): William Wagner
18. Mother's Name (First, Middle, Maiden Surname): Beatrice Gertrude McManus

19a. Informant's Name/Relationship (Type, Print): Charlotte Wagner
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2423 Southwest Road Baltimore, Maryland 21234

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Druid Ridge Cemetery
Date: 8/19/99
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: William Black
22. Name and Address of Facility: John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Prostate Cancer	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D43725
29d. Date signed (Month, Day, Year): 8/16/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): TARIQ MAHMOOD 201-109 Back River Neck Rd Baltimore MD 21221

State Registrar

31. Date filed (Month, Day, Year): AUG 18 1999
32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

MD CHASE

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ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25990

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Rachel Zickefoose
2. Date of Death: Month August Day 16 Year 1999
3. Time of Death: 10 35 pm
4a. Facility Name (If not institution, give street and number): Johns Hopkins Bayview Medical Ctr.
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-34-4133
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 76 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 3, 1923
9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Edgemere
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2825 Lodge Farm Road Apt. 114
10f. Zip Code: 21219
10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 Years; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Assembly Line Worker
16b. Kind of Business/Industry: Manufacturing

17. Father's Name (First, Middle, Last): Leon Dehenaut
18. Mother's Name (First, Middle, Maiden Surname): Elna Hire

19a. Informant's Name/Relationship (Type, Print): George F. Zickefoose/Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1911 Oxley Road Dundalk, Maryland 21222

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) Entombment
20b. Place of Disposition (Name of cemetery, crematory or other place): Moreland Mausoleum Date: 8/20/99
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: George E. Ruck
22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. metastatic gallbladder cancer — 6 months
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Singhal
29c. License number: RES-000
29d. Date signed (Month, Day, Year): August 16, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SUNIL SINGHAL 4949 Eastern Avenue Johns Hopkins Bayview Medical Ctr. Baltimore, Maryland 21224

State Registrar

31. Date filed (Month, Day, Year): AUG 18 1999
32. Registrar's Signature: Emma G. Sparks

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ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25991

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Blandine Zimring
2. Dete of Deeth: Month 7 Day 28 Year 99
3. Time of Deeth: 6:50 am
4a. Facility Neme (If not institution, give street end number): Mercy Medical Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

Funeral Director

5. Social Security Number: 055-10-7865
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthdey): 87 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Yeer): Dec. 31, 1911
9. Birthplece (Stete or Foreign Country): NY

Usuel Residence of Decedent

10a. Stete: MD
10b. County: HOWARD
10c. City, Town or Location: ELLICOTT CITY
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 4126 DEE JAY DRIVE
10f. Zip Code: 21042
10g. Citizen of Whet Country?: USA

11. Meritel Status: 1☐ Never Married 2☐ Merried 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - Americen Indien, Bleck, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 4 | College (1-4or 5+):
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): TEACHER
16b. Kind of Business/Industry: EDUCATION

17. Father's Neme (First, Middle, Last): HENRY JACOBS
18. Mother's Neme (First, Middle, Maiden Surneme): IDA PAVLOVSKY

19a. Informent's Name/Relationship (Type, Print): MICHAEL ZIMRING - SON
19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 4126 Dee Jay Drive, Ellicott City, MD 21042

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☒ Removel from State 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other place): MT. JUDAH CEMETERY
Date: 8/1/99
20c. Location - City or Town, Stete: RIDGEWOOD, NY

21. Signeture of Funerel Service Licensee: ▶ Sayre Feldman per DVR
22. Neme end Address of Fecility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert failure. List only one cause on eech line.

Approximete Interval Between Oneet end Death

Immediete Ceuse (Finel disease or condition resulting in deeth)
e. Pneumonia — 10 days
Due to (or es e consequence of):
b. Aspiration
Due to (or es e consequence of):
Sequentially list conditions, if eny, leading to Immediete cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in deeth) Last
c. Multi-infarct Dementia
Due to (or es e consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Colon Cancer
Emphysema

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☑ No
24b. Were eutopsy findings eveilable prior to completion of cause of death? 1☐ Yes 2☑ No

25. Wes case referred to medical examiner? 1☐ Yes 2☑ No
26. Piece of Deeth (Check only one): Hospitel: 1☑ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☑ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and menner es steted. 2☐ Medical Examiner: On the basis of exemination and/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner steted.
29b. Signeture end title of certifier: ▶ [signature]
29c. License number: D42908
29d. Date signed (Month, Day, Yeer): 7/28/99
30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): David Schantz, M.D. 808 S. Conkling St. Balt. MD 21224

State Registrar

31. Dete filed (Month, Dey, Yeer): AUG 18 1999
32. Registrer's Signeture

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25992

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Nancy Belle Appleton
2. Date of Death: Month July Day 29 Year 1999
3. Time of Death: 8:50pm
4a. Facility Name (If not institution, give street and number): North Arundel Hospital
4b. City, Town, or Location of Death: Glen Burnie
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 215-30-5791
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 65 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 2, 1934
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Millersville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 8688 Veterans Highway
10f. Zip Code: 21108
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): John M. Speake, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Doris Belle Dells

19a. Informant's Name/Relationship (Type, Print): Margaret Nelka/daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8688 Veterans Hwy., Millersville, MD 21108

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory
Date: Aug 2 1999
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: Barranco & Sons, P.A. Severna Park F.H. 495 Gov. Ritchie Hwy., Severna Park, MD 21146

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Congestive Heart Failure — 1 yr
Due to (or as a consequence of):
b. Lung cancer
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Atrial fibrillation, Chronic obstructive lung disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: , MD
29c. License number: D48006
29d. Date signed (Month, Day, Year): July 29th 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): KOFI BOATEY, 301 Hosp. Dr, Glen Burnie, MD 21061

State Registrar

31. Date filed (Month, Day, Year): AUG 03 1999
32. Registrar's Signature: G. Speake

DHMH 16 Rev 6/95

ORIGINAL

Nancy B. Appleton

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 99 25993

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOSEPH P. ANTHONY, SR.

2. Date of Death (Month, Day, Year): AUGUST 05, 1999

3. Time of Death: 1:45AM

4a. Facility Name (If not institution, give street and number): MILLENNIUM HEALTH AND REHABILITATION CENTER

4b. City, Town, or Location of Death: EDGEWATER

4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 577-14-3541

6. Sex: 1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb. 12, 1914

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Edgewater

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 3311 Pocahontas Drive

10f. Zip Code: 21037

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 4 yrs.

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Fireman

16b. Kind of Business/Industry: D.C. Fire Department

17. Father's Name (First, Middle, Last): Jausas Petras Antonovage

18. Mother's Name (First, Middle, Maiden Surname): Alice Lukas

19a. Informant's Name/Relationship (Type, Print): Joseph P. Anthony, Jr./ Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3311 Pocahontas Drive Edgewater, MD 21037

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cemetery

Date: 8-7-99

20c. Location - City or Town, State: Wheaton, Maryland

21. Signature of Funeral Service Licensee: Martel Eller

22. Name and Address of Facility: GEORGE P. KALAS FUNERAL HOME 2973 SOLOMONS ISLAND ROAD EDGEWATER, MD. 21037

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. HEMIPLEGIA — More than 2 weeks

Due to (or as a consequence of):

b. CEREBRO VASCULAR ACCIDENT — More than 2 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Gyanchand Surana

29c. License number: D 50653

29d. Date signed (Month, Day, Year): AUGUST 5, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): GYAN CHAND SURANA 5851 DEALE CHURCHTON ROAD DEALE M.D. 20751

State Registrar

31. Date filed (Month, Day, Year): AUG 09 1999

32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25994

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Arthur G. Alford

2. Date of Death (Month, Day, Year): July 21 99

3. Time of Death: 8:30 pm

4a. Facility Name (If not institution, give street and number): Charlestown Care Center

4b. City, Town, or Location of Death: Catonsville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 151-09-1220

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 84 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept 27, 1914

9. Birthplace (State or Foreign Country): Texas

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 709 Maiden Choice Lane

10f. Zip Code: 21228

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Operator

16b. Kind of Business/Industry: Railroad

17. Father's Name (First, Middle, Last): Mart Alford

18. Mother's Name (First, Middle, Maiden Surname): Della Harrison

19a. Informant's Name/Relationship (Type, Print): Patricia S. Judefind/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 387 Wilett Court, Severna Park, MD 21146

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Meadowbrook Memorial Gar.

Date: July 25 1999

20c. Location - City or Town, State: Driver, VA

21. Signature of Funeral Service Licensee: James E. Barranco

22. Name and Address of Facility: Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Coronary Artery Disease — Years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one) — Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 ☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Arthur Salazar MD

29c. License number: D51051

29d. Date signed (Month, Day, Year): July 22, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Andrei Salazar 711 Maiden Choice Lane, Catonsville, MD, 21228

State Registrar

31. Date filed (Month, Day, Year): JUL 26 1999

32. Registrar's Signature: Brenda B. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020 mcg

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Name: Arthur Alford

Division of Vital Records, P.O. Box 68760,

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25995

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Margaret Ann Baggott

2. Date of Death — Month: August; Day: 2; Year: 1999

3. Time of Death: 10:50 AM

4e. Facility Name *(If not institution, give street and number)*: Chesapeake Hospice House

4b. City, Town, or Location of Death: Linthicum

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 217 05 2735

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 85 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 11/27/1913

9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Severn

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1654 Shannon O Circle

10f. Zip Code: 21144

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 5; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Waitress

16b. Kind of Business/Industry: Hospitality

17. Father's Name *(First, Middle, Last)*: Not Available Fischer

18. Mother's Name *(First, Middle, Meiden Sumeme)*: Edith Stull

19e. Informant's Name/Relationship *(Type, Print)*: Barbara Williams (daughter)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1654 Shannon O Circle, Severn MD 21144

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Ft Lincoln Cemetery

Date: 8/4/99

20c. Location - City or Town, State: Brentwood MD

21. Signature of Funeral Service Licensee: ▶ Melanie Wilhelm Hagner

22. Name and Address of Facility: Advent Funeral Services, Annapolis MD 21401

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart failure — 8/98

Due to (or as a consequence of):

b. Ischemic Heart Disease — 9/

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part ii. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation

Chronic Renal failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]

29c. License number: D31744

29d. Date signed *(Month, Day, Year)*: 8-3-1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): G. Heban MD 1600 Crain Highway South #208 Upper Marlboro Maryland

State Registrar

31. Date filed *(Month, Day, Year)*: AUG 03 1999

32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25996

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Annelise H. Bailey
2. Date of Death (Month, Day, Year): July 19, 1999
3. Time of Death: 6:10 pm
4a. Facility Name (If not institution, give street and number): Futurecare Chesapeake
4b. City, Town, or Location of Death: Arnold
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 328-18-2698
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 93 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Mar 8, 1906
9. Birthplace (State or Foreign Country): Germany

Usuet Residence of Decedent

10a. Stete: MD
10b. County: Anne Arundel
10c. City, Town or Location: Severna Park
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 505 Kegworth Court
10f. Zip Code: 21146
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): | College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): Martin Harbeck
18. Mother's Name (First, Middle, Maiden Surname): Rakobrandt (unknown)

19a. Informent's Neme/Reletionship (Type, Print): Lars Roesch / son
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 505 Kegworth Court, Severna Park, MD 21146

20a. Method of Disposition: 1☐ Buriel 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory | Date: July 22 1999
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Barranco & Sons
22. Neme and Address of Facility: Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146

Physician /Medical Examiner

25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. pneumonia — hours
Due to (or es a consequence of):
b. dysphagia — months
Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last
c. advanced dementia — years
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
osteoporosis, type 2 diabetes, atherosclerotic vascular disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Neturat 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner stated.
29b. Signature and title of certifier
29c. License number: D41955
29d. Date signed (Month, Day, Year): 7-21-99

30. Neme end address of person who completed cause of death (Item 23a) (Type, Print): Rebecca D Bond MD 479 Jumpers Hole Rd Severna Park MD 21146

State Registrar

31. Date filed (Month, Day, Year): JUL 2 6 1999
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

mcg Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25997

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: SHIRLEY DIXON BEDELL

2. Date of Death: Month July Day 24, Year 1999

3. Time of Death: 8:00 p.m.

4a. Facility Name *(If not institution, give street and number)*: Hospice House

4b. City, Town, or Location of Death: Easton

4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 119-14-6688

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 78 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 13, 1921

9. Birthplace *(State or Foreign Country)*: Penna.

Usual Residence of Decedent

10a. State: Maryland

10b. County: Talbot

10c. City, Town or Location: St. Michaels

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 24790 Swan Rd.

10f. Zip Code: 21663

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Home

17. Father's Name *(First, Middle, Last)*: Earle Dixon

18. Mother's Name *(First, Middle, Meiden Surname)*: Quida Dildg

19a. Informant's Name/Relationship *(Type, Print)*: Malcolm W. Bedell Husband

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: P.O. Box 11, St. Michaels, Maryland 21663

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Capitol Crematory

Date: July 26, 1999

20c. Location - City or Town, State: Dover, Delaware

21. Signature of Funeral Service Licensee: Harrison E Leonard

22. Name and Address of Facility: Harrison E. Leonard Funeral Home, 312 S. Talbot St. St. Michaels, Maryland 21663

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Lung Carcinoma — 3.5 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* Hospice House

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M D [illegible]

29c. License number: D 47232

29d. Date signed *(Month, Day, Year)*: 7/26/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mary S. DeShields, M.D., 509 Idlewild Ave, Easton, Md. 21601

State Registrar

31. Date filed *(Month, Day, Year)*: JUL 28 1999

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25998

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Curtis Batson

2. Date of Death: Month July, Day 30, Year 1999

3. Time of Death: 9:10 PM

4e. Facility Name (If not institution, give street and number): Genesis ElderCare - The Pines

4b. City, Town, or Location of Death: Easton

4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 220-28-1366

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 64 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): 12-31-1934

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Caroline

10c. City, Town or Location: Federalsburg

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: Davis Ln.

10f. Zip Code: 21632

10g. Citizen of What Country? USA

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Chicken Catcher

16b. Kind of Business/Industry: Poultry

17. Father's Name (First, Middle, Last): Johnnie Batson

18. Mother's Name (First, Middle, Maiden Surname): Alice Johnson

19a. Informant's Name/Relationship (Type, Print): Wendall Batson (Nephew)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 29627 Dover Rd, Easton, md. 21601

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Capitol Crematory

Date: 8/6/99

20c. Location - City or Town, State: Dover, Delaware

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Bennie Smith Funeral Home, P.O. Box 1687, Easton, md. 21601

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Hypoxia — hours

Due to (or as a consequence of):
b. Non-small cell carcinoma of the lung — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Anemia
Cachexia

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D25955

29d. Date signed (Month, Day, Year): 7.31.99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): MICHAEL CROWLEY, MD 508 IDLEWILD AVENUE EASTON, MD 21601

State Registrar

31. Date filed (Month, Day, Year): AUG - 4 1999

32. Registrar's Signature: [signature] B. Sparks

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 25999

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Edward Stone Collins, Jr.

2. Date of Death (Month, Day, Year): July 31, 1999

3. Time of Death: 11:45 A.M.

4a. Facility Name (If not institution, give street and number): Millennium Extended Care -South River

4b. City, Town, or Location of Death: Edgewater

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 577-01-9136

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 7, 1909

9. Birthplace (State or Foreign Country): Washington, D.C.

Usual Residence of Decedent

10a. State: Maryland

10b. County: St. Mary's

10c. City, Town or Location: Leonardtown

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 18910 McKays Beach Road

10f. Zip Code: 20650

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9th | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Repairman

16b. Kind of Business/Industry: Telephone Company

17. Father's Name (First, Middle, Last): Edward Stone Collins, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Rebekah Chick

19a. Informant's Name/Relationship (Type, Print): Edward P. Collins/ Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 128 Oakwood Road Edgewater, Maryland 21037

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory | Date: 8-2-99

20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Hemiplegia	7 days
Due to (or as a consequence of): b.	Cerebrovascular Accident	7 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c.	Cerebral Atherosclerosis	more than 10 years
Due to (or as a consequence of): d.		

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Hypercholesterolemia

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] Gyan Chand Surana M.D.

29c. License number: D50653

29d. Date signed (Month, Day, Year): 8-1-1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Gyan Chand Surana, M.D. 5851 Deale Churchton Road Deale, MD 20751

State Registrar

31. Date filed (Month, Day, Year): AUG 03 1999

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 26000

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Lucy Virginia Courtney

2. Date of Death Month Day Yeer: July 31, 1999

3. Time of Death: 4:15 pm

4a. Facility Name *(If not Institution, give street and number)*: 1117 Woodlyn Road

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 216-36-6795

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthdey)*: 76 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Yeer)*: Aug 16, 1922

9. Birthplace *(State or Foreign Country)*: W. Virginia

Usual Residence of Decedent

10e. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Annapolis

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 1117 Woodlyn Road

10f. Zip Code: 21401

10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Home

17. Father's Name *(First, Middle, Last)*: Henry Clay McCormick

18. Mother's Name *(First, Middle, Meiden Sumeme)*: Mary Louise Mock

19e. Informant's Name/Reletionship *(Type, Print)*: Irwin Courtney/Husband

19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 1117 Woodlyn Road, Annapolis, MD 21401

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Piaca of Disposition *(Neme of cemetery, cremetory or other piece)*: Metro Crematory

Date: Aug 4 1999

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee ▶ James E. Byrne

22. Name end Address of Facility: Barranco & Sons, P.A. Severna Park F.H. 495 Gov. Ritchie Hwy., Severna Park, MD 21146

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreat, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Cancer of Ovary — 2 months

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due fo (or es e consequence of):

c. Due fo (or as a consequence of):

d.

Part II. **Other significant conditions** contributing fo death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings aveilable prior to compiefion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Deeth *(Check only one)*: Hospital: 1☐ Inpatienf 2☐ ER/Outpatienf 3☐ DOA Other: 4☐ Nursing Home 5☒ Residenca 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Sulcide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Phyeician:** To the best of my knowledge, death occurred et the time, dete end plece, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, date and piace, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier ▶ Peter R Graze MD

29c. License number: D16364

29d. Date signed *(Month, Day, Year)*: August 2, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Peter R. Graze, 900 Bestgate Road, Annapolis, MD 21401

State Registrar

31. Date filed *(Month, Dey, Yeer)*: AUG 06 1999

32. Registrar's Signature ▶ [signature]

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

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